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THE REPORTS OF A STUDY GROUP TO EVALUATE REHABILITATION POTENTIAL, ESTABLISHED BY THE INSTITUTE FOR REHABILITATION SERVICES PLANNING COMMITTEE, IS PRESENTED. "THE BASIC COMPONENTS OF AN ADEQUATE VOCATIONAL ASSESSMENT" DISCUSSES THE MEDICAL, SOCIAL, PSYCHOLOGICAL, AND EDUCATIONAL-VOCATIONAL COMPONENTS OF THE INDIVIDUAL WHICH SHOULD BE EVALUATED BY THE FIELD REHABILITATION COUNSELOR. "GUIDELINES FOR SELECTION OF CLIENTS FOR FORMALIZED (FACILITY) EVALUATION" DISCUSSES GENERAL GUIDELINES FOR CLIENT REFERRAL TO APPROPRIATE FACILITIES, SPECIFIC GUIDELINES APPLICABLE TO THE INDIVIDUAL COUNSELOR OR CLIENT, AND ADVANTAGES, DISADVANTAGES, AND COUNSELOR RESPONSIBILITY IN USING FORMAL FACILITY EVALUATION. "ORGANIZATION AND UTILIZATION OF COMMUNITY RESOURCES FOR DETERMINING VOCATIONAL POTENTIAL OF REHABILITATION CLIENTS" DISCUSSES THE PRINCIPLES OF COMMUNITY ACTION, ESTABLISHMENT OF COMMUNITY NEEDS, THE ROLE OF THE STATE AGENCY IN SETTING UP THE FACILITY, AND THE ROLE OF THE REHABILITATION COUNSELOR IN COMMUNITIES WHERE A FACILITY EXISTS. FIFTEEN APPENDIXES INCLUDE EXAMPLES OF INSTRUMENTS AND PROCEDURES IN USE IN SPECIFIC REHABILITATION FACILITIES, A SURVEY OF MEDICAL SCHOOLS RECEIVING VOCATIONAL REHABILITATION ACT TEACHING GRANTS, AND SUGGESTIONS FOR FURTHER STUDY. A GENERAL BIBLIOGRAPHY AND A BIBLIOGRAPHY ON EVALUATION OF DISABILITY CATEGORIES ARE INCLUDED. THIS DOCUMENT IS AVAILABLE AS FS13.207--66-23 FOR 60 CENTS FROM SUPERINTENDENT OF DOCUMENTS, U.S. GOVERNMENT PRINTING OFFICE, WASHINGTON, D.C. 20402. (BS)

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Third Institute on
Rehabilitation Services
May 23 - 27, 1965

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Training Guides
in
Evaluation of Vocational Potential
for
Vocational Rehabilitation Staff

The Committee on Evaluation of Vocational Potential

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May 23-27, 1965
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The materials in this publication do not necessarily represent the official views of the Vocational Rehabilitation Administration nor of State vocational rehabilitation agencies. They do, however, reflect an attempt by State vocational rehabilitation workers to explore a significant aspect of their programs in order to encourage evaluation and stimulate professional growth.

FOREWORD

Not many years ago, evaluation of rehabilitation potential consisted of an informal process of collecting information on which the counselor based his decision about how best to aid the client to retain or achieve gainful employment. As the necessity for a more thorough evaluation emerged with the introduction of expanded concepts of rehabilitation, a wide variety of processes and techniques were made available to the field. These efforts have resulted in more formal evaluation procedures and have produced a wealth of literature on the subject.

The present effort to focus attention on the evaluation of rehabilitation potential resulted from suggestions made by State agency supervisory personnel. The Institute on Rehabilitation Services was charged to develop guidelines suitable for use in State agency training.

This booklet represents the work of the first year of the IRS Study Committee on Evaluation of Vocational Potential. The Committee will continue for a second year to devote attention to this increasingly important aspect of the rehabilitation process.

Joseph Hunt
Assistant Commissioner

PREFACE

This report is not a finished product or a scholarly compendium arranged in a logical manner. It should be considered as a guide for further study and investigation. The study Committee for the Evaluation of Vocational Potential was charged with the responsibility of developing guidelines for use by the counselor in evaluating the vocational potentials of handicapped persons who are referred for vocational rehabilitation services. (The specific charges were to identify the basic components of an adequate vocational assessment, to develop guide lines for the selection of clients in need of formalized work evaluation and to develop procedures for organizing community resources to secure needed evaluative services.) A beginning was made in the short period of time available to the Committee, however, additional study and further research will be needed to adequately carry out the above charges.

Much of the material prepared by the Planning Committee and discussed at the Institute was not original. It did, however, represent some of the thinking of Committee Members based on their experience in the field of rehabilitation. It is also based on a rather limited amount of the pertinent literature in the field. The Committee realizes that "the surface has only been scratched", and that an enormous amount of study and research still needs to be done in this very important area of the rehabilitation process. It is hoped that the material contained in this report will be useful as a training aid and that it will serve as a basis for further study at future I.R.S. sessions.

The Committee was largely composed of supervisory personnel and individuals responsible for staff development in their respective agencies. They were assisted by resource people from the National and Regional Vocational Rehabilitation Offices and a limited number of participants from other disciplines, including knowledgeable people from University faculties. It is recommended, however, that future sessions have more participation by field counselors and more participants from University faculties.

The assistance of Mr. Neal Little, Hot Springs Rehabilitation Center, Hot Springs, Arkansas; Mr. Seth Henderson, Oklahoma State University, Stillwater, Oklahoma; Mr. H. B. Simmons, Vocational Rehabilitation Administration, Dallas, Texas, in the compilation of material, writing and editing of the final report, is gratefully acknowledged.

The members of the Planning Committee and all other participants on the Study Committee on the Evaluation of Vocational Potential are hereby recognized and extended an expression of thanks for their deliberations, suggestions and recommendations which formed the basis for this report.

George F. Cundiff

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INTRODUCTION

Clayton A. Morgan, Ed. D.*

The I.R.S. Planning Committee for 1965 established a Study Group for the "Evaluation of Rehabilitation Potential." The need for such a study has become more evident in recent years - particularly since the passage of Public Law 565.

The bases for rehabilitation services have been broadened. Handicapped persons not formerly considered feasible now constitute greater percentages of case loads. Some counselors and other rehabilitation personnel devote most or all of their professional efforts to working with such clients.

New dimensions of what constitutes a handicap are being taken into consideration. We are giving more attention to the culturally and socially deprived. More and more we are recognizing that disability is not something we can neatly peg or classify. How much do we know simply by identifying the principal disabling condition? How foolish it is to ask, "What can a man do who has had a leg amputated?" It makes about as much sense to ask "How short - or long - is a stick?"

Our questions must be much more specific, even while they are asked in a broad context. One such broad context is the sprawling thing we call "evaluation." If we hope to do justice to our client, there must be an assessment of him. But is evaluation simply assessment? And if so, assessment of what? Is this playing with words? Is there any known way(s) at present to approximate the goal of "total" evaluation? For that matter, what do we mean by an "adequate" evaluation? What are the principal areas or components which should be included in an evaluation of rehabilitation potential? And again, potential for what?

The committee charged with developing the "whys" and "wherefores" of rehabilitation potential have wrestled at length with these and other questions. Early it became evident that for purposes of discussion, the subject would need to be divided and sub-divided. The basic components of evaluation in rehabilitation were identified under the four headings of: 1) Medical; 2) Psychological; 3) Social; 4) Educational and Vocational. In addition, as part of the general charge, a sub-committee has developed some guidelines for the selection of clients in need of formalized evaluation. Another sub-committee has developed some procedures to be followed in organizing and utilizing community resources to supply the kind of evaluation services felt to be necessary.

The Study Group realized that it is folly to try to draw a hard and fast line between what constitutes social, medical, psychological, vocational and educational factors. There is a tremendous overlap. Who would dare to identify any one of these components as being "pure" and unrelated in some degree to the other areas?

Even so, though diffuse and interrelated, it is also true that in certain instances there is need for more evaluation in the medical area. In another case it may be evident that there is a pressing need for more evaluation in depth in one of the other areas.

INTRODUCTION (Continued)

Again we are faced with the fact of individual differences. Certainly no counselor would be expected to "check off" every client on every item on some master evaluation sheet. Circumstances present in each case will determine what aspects merit most attention and to what degree evaluation will be needed.

The Study Group felt that persons working with a particular disability group, e.g., the deaf or blind, could best determine which factors would be most appropriate for their purposes. No attempt has been made to identify aspects of evaluation which might apply more to one group than another.

The Study Group further realized that this report is far from being all-inclusive. While it is believed that anyone working in rehabilitation will find in this report many worthwhile suggestions regarding evaluation, specialists working in certain circumstances with a particular disability group might wish to modify some of the ideas presented or develop others for their own setting.

Too, early in its deliberations the Study Group became aware of some approaches to evaluation which have been formalized and given certain names, e.g., the Tower. Many Vocational Rehabilitation Administration sponsored Research and Demonstration projects contain suggestions for a more comprehensive evaluation of the client, use of community resources in evaluation, and guidelines for the selection of clients in need of formalized evaluation. Without trying to make fine definitions about such terms as "pre-vocational testing, work sample", etc., brief mention will be made of several of these ideas and approaches.

Too, no attempt has been made to evaluate the relative effectiveness of "the team" approach versus the approach of the counselor who is assigned a rural area and must synthesize his information from a variety of sources.

Many questions and problems in evaluating rehabilitation potential remain to be resolved. Some of these will be answered in part by the effects of new legislation. Others can be approached by a further study of materials which are already available. The Study Group repeatedly had to choose among many reports and publications. Care has been taken to try to include representative samples.

For the purposes of this study, it is hoped that what is presented here will serve to be of immediate applied use. There is an additional objective: we hope this report will stimulate others to undertake additional study in this fascinating area of rehabilitation.

---

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SECTION A

THE BASIC COMPONENTS OF AN ADEQUATE VOCATIONAL ASSESSMENT

This section of the report is concerned with the first charge to the Committee which was "To identify the basic components of an adequate vocational assessment." In considering the above charge, the Committee felt that the word rehabilitation might be substituted for vocational in the above charge for clarification purposes. Since such a change would merely be a matter of semantics, the Editorial Committee decided to use the original charge for discussion purposes in this report. The above suggestion, however, is mentioned in order to reflect the thinking of Committee members.

The approach to be followed in reporting this section of the report will be to include some thoughts and opinions of Committee members concerning the four basic components of a vocational assessment and related topics. Some representative documents used by State agencies in the evaluative process and related material are included in the appendices of the report.

In its deliberations, the Committee was cognizant of the basic requirements for eligibility for vocational rehabilitation services. That is, an individual must have a physical or mental condition which causes an impairment of functional capacities. Such impairment or impairments must, in turn, cause a substantial vocational handicap. In addition, there must be reasonable assurance, based on accepted vocational rehabilitation principles, that the applicant can be prepared for or returned to remunerative employment. It was also fully aware that an arbitrary grouping of the basic components under four general headings would result in considerable repetition and overlapping. It, likewise, realized that the counselor's evaluation, in order to determine eligibility and plan an appropriate rehabilitation plan for the client, requires a clinical judgment by him, wherein the several bits of information tend to form a gestalt or meaningful pattern with a variety of relationships.

The Committee also emphasized that, in addition to identifying and considering the basic components, the counselor must consider related factors in his evaluation. Furthermore, the weight or importance of each component in a particular evaluation, depends on the individual case.

The Committee was aware of the fact that some of the information for an evaluation would be secured by the individual counselor, according to his own professional competence, some of it would be secured from local sources on a fee or complimentary basis and that in some instances it would need to be secured from a facility organized to furnish evaluative services.

THE MEDICAL COMPONENT

Impairment and Limitations

The existence of a disability or impairment should be established as a result of medical examination and judgment (including a psychological examination when necessary.)

The report should be expressed in anatomical or pathological terms in such a way that the counselor can identify them in making his evaluation.

There should be a prognosis regarding the removal or amelioration of the disability. The explanation should include more than general terms such as fair and good.

Major functional limitations should be spelled out where possible. If difficult in the individual case, limitations ordinarily listed for a person with a certain condition should be enumerated (asthma, diabetes, etc.).

In addition to functional limitations, activities and environmental conditions which applicant should avoid, will be listed where applicable.

Since the evaluation of individuals for work potential traditionally has tended to emphasize the negative factors, it is important that a counselor know the remaining capacities of an applicant. Such capacities should be evaluated or compared to a normal person of like physical, mental, educational, or cultural classification. For instance, comparison of the remaining capacities of an unskilled worker with those of a professional or highly skilled group would serve no useful purpose.

Reports

A report from a physician, psychiatrist or from a psychologist is the only means by which the counselor, except from observation, has to learn about an applicant's condition (Diagnosis, limitation, and assets).

The report should, therefore, clearly enumerate the above named minimal information on prescribed agency forms or in narrative form on a level which can be understood by the counselor. It should, likewise, be confined to the medical aspects of the case and should not list specific objectives or occupations which might or might not be appropriate for the applicant. If such a recommendation is made, it should clearly be indicated that it is only a suggestion or explanation of the client's condition or limitations.

Specific recommendations for further diagnostic studies should be made if indicated. Recommendation regarding surgery or treatment, likewise, should be spelled out. If a definite prognosis cannot be made, the examiner or examiners should give some explanation of the results which can normally be expected in similar cases. For example, the examiner could give some explanation of the nature of a spinal fusion and the results which could be expected under normal circumstances.

Background

The basic components have been identified. These components are thought to be the four most commonly accepted areas. It has been stated that any such division is purely arbitrary, there being considerable overlapping and repetition. It has also been pointed out that the degree to which tangible and intangible factors in each of these areas is integrated into a clinical judgment or consensus, and in turn integrated with the other similarly derived components, does adequate evaluation of rehabilitation potential occur. It has likewise been pointed out that the individual factors have innumerable variable relationships in the evaluation of any single individual, and that factors outside these evaluated components such as location, resources and practices may play a role in the manner in which these components are evaluated. The innumerable variable relationships may account for disability residing largely in one of the component areas. The degree to which it resides in each and all components will largely determine the degree to which more elaborate methods of evaluation and integration will be necessary.

While concerned largely with the medical component as an entity in this instance, its relationship to the evaluative process must be considered inasmuch as special kinds of information are needed. Medical Consultation has previously been studied by the Institute on Rehabilitation Services and has defined the counselor-medical consultant relationship in ways that have a direct bearing on the evaluative process in that the concerns of the medical component became integrated with the other components and describe a kind of comprehensive evaluation. That study described a face-to-face visitation where the medical consultant clarified, explained, and intepreted medical information, gave advice on medical and non-medical services so that the counselor might discharge his responsibility for making decisions regarding eligibility and ineligibility and the provision of services. The counselor brought information about social, psychological, environmental, educational, and vocational background that might relate to medical problems. The medical consultant could recommend other types and sources of medical investigation and treatment in the most effective sequence and prognosticate. Thus, the medical aspects of cases and the relationship of these aspects to the rehabilitation process would emerge. It was pointed out that it should be recognized by counselor and medical consultant that often medical decisions may be altered by social, cultural, psychological and vocational factors to the same extent that social, psychological, and vocational potentialities of the client may be altered by the nature of the medical decisions.

Certain supervisory elements of the medical consultation process assured comprehensive evaluation of the potential rehabilitant through coordination and integration. It was suggested that the interaction of counselors and consultants often resulted in added enthusiasm for both and in better service to the rehabilitation client. It can be as easily said that increase number of representatives of the various components, when necessary, likewise result in added enthusiasm and better services to the rehabilitation client. Provided the needs of the particular client involved could be served by the communication of this type information, further discussion of pertinent data may be unnecessary. It might be anticipated that the nature and severity of the impairment and the resulting severity of the disability when the other components were integrated would largely determine the degree to which the client's needs could be met.

Rehabilitation in Medical Practice

A review of the Handbook for Medical Consultants in the State Vocational Rehabilitation program reveals evidence that the rehabilitation process is thought to require the skills and knowledge of many professional persons whose talents and efforts must be pooled, and that the process depends for its success upon broad understanding and constructive cooperation from health, welfare, education, and other agencies and organizations. Standards require that prior to and as a basis for formulating the individual's plan of vocational rehabilitation, there will be a thorough diagnostic study which will consist of a comprehensive evaluation of pertinent medical, social, psychological and vocational factors adequate to establish presence of a limiting condition, appraise the current health status, and potential for correction or improvement; and provide a realistic basis for selection of an employment objective. Translating this information regarding impairment, current health status, and potential for improvement for the counselor assists him in understanding the individual's functional capacities and limitations. The comprehensive approach to medical diagnosis and treatment of the severely disabled is particularly emphasized inas much as the pooling of information and integration of the medical and medically related findings in group discussion may result in a more integrated diagnosis.

Standards for a wide range of physical restoration services insure quality of care in clinics, hospital and special facilities. There are provisions for treatment of complications and for acute care while under continued supervision as in extended treatment with comprehensive re-evaluation in the event that a new rehabilitation plan should be formulated. More comprehensive care is also facilitated by allowing the client to use his own physician who may provide useful social and psychological data, by the use of current elaborate hospital or clinic records, or by the participation of the examining physician in the agency staff conference for purposes of total evaluation of client. Finally, some increased knowledge should accrue from a policy of complete evaluation even when the disability appears to be an isolated one, from obtaining new and sometimes better service than has been previously available, from providing pertinent collected information to the new examining physician after explaining the objectives of the program or requesting information regarding capacities for certain jobs or environments, and from assuming responsibility for need for interpreting to the client a need for medical care. While these practices are dictated by policy and are required by a program with sound operating principles, some are probably influenced by other factors; but all serve the needs of a comprehensive approach to rehabilitation planning. Many of the physician functions described are dictated by policy but many are of the nature of routine physician services related to the special process of the evaluation of rehabilitation potential and occur in many other settings.

As pointed out above a thorough diagnostic study consists in part of a comprehensive evaluation of pertinent medical factors relating to:

a. Adequacy of evidence as to the presence of an impairment and the individual's total health situation.

b. Recommendations for further medical diagnostic services.

c. Analysis of functional limitations arising from the impairment.

d. Recommendations for physical restoration services and opinion as to their probable outcome.

e. Recommendations for renewal, extension, or termination of physical restoration services with brief summary of basis for action, and

f. Evaluation of clients' needs for continuing medical care or follow-up after case closure.

This study does not propose to take into consideration the variation in practices within agencies but many factors such as the need and availability of medical consultants within the agency, the use of the client's own physician, the use of current clinic and hospital records, the use of specialists as consultants, and the use of facilities for physical restoration services makes it necessary to consider factors relative to the adequacy of these services for rehabilitation planning purposes. It would appear that item (c), analysis of functional limitations arising from the impairment, is the only area that is frequently missing in routine medical reports. This item will be explored in the various areas of practice and rehabilitation planning as it relates to the rehabilitation process.

Rehabilitation in Hospitals

In recent years a greater interest and progress in treating the effects of congenital conditions, the effects of trauma, and the chronic and degenerative diseases has resulted in rehabilitation becoming a concern for the hospital and of medical education. Some of this has resulted from economic pressures to get the patient out of the hospital and elevated to independence and some from public demands; the way having been pointed by volunteer groups and special programs. The medical profession has been prompted to think of rehabilitation services earlier in the history of impairment and the management of some impairments have been noted to be enhanced by rehabilitation concepts and practices. This kind of program in hospitals has been accomplished largely through team efforts. Many hospitals have centered their programs for such care around a department or a service of physical medicine and rehabilitation. This activity in the larger medical centers has come to be the focal point for the formalized teaching of rehabilitation techniques and concepts to specialists in this area as well as at the medical undergraduate level and, more recently, to other specialties in the rehabilitation field. These teaching and services programs have, in many instances, had representatives from the state agency rehabilitation programs, resulting in the full complement of disciplines which participate in an evaluation and planning program with or without formal agreement. (See Appendix I.)

The patients or clients most often studied or served in the hospital setting are likely to be the complex or severely disabled where a great deal of integration of the individual evaluations or services is necessary. Inasmuch as these programs are hospital based, much of the concern centers around the coordination of the medical specialty services necessary to diagnose impairment and evaluate potential for improvement. Not infrequently, considerable effort must be given to helping the patient adjust to a new self image or concept and to cooperate with and accept treatment programs and, at times, long range vocational goals. The newly disabled of severe degree can, at times, put to test the best that an integrated and coordinated multidisciplinary team has to offer. In many instances services in this setting will include pre-vocational exploration.

The Vocational Rehabilitation Administration has stimulated hospital based programs and practices by supporting training and research in this type setting. As a portion of the current study a survey of the medical schools receiving teaching grants was carried out to determine to what degree these schools had representatives of the various components participating in joint rehabilitation evaluation, and to what degree teaching of these component disciplines occured in this setting. (See Appendix II.) Further pursuit of information in this regard in schools not responding and in schools not receiving teaching grants revealed that practices in those schools were essentially the same. In some locations, exposure to these concepts and practices was obtained through convenient affiliation with special hospitals or centers where this type of practice existed. A review of the 1964 annotated listing of research and demonstration projects revealed that 323 of 836 projects are located in Universities, University Medical Centers, Research Institutes or Hospitals and that 26 of 52 projects employing or studying comprehensive services are located in University Medical Centers or Hospitals. In these locations much of the effort to standardize methods of defining functional limitations has taken place. The use of physical ability rating forms such as that of Harman has become common practice. (See Appendix III.) The work of Sokolow and others has amplified the dimensions of the components of vocational assessment through the approach to disability evaluation. The work of Riviere in developing the Rehabilitation Codes also gives some insight into the complexity of evaluating severity of disability and takes into consideration the significance of the various components. (See Appendix IV.) The complexity of indicating physical resources or ability is manifest in the coding of physical resources currently available and the amount, duration, and intensity of physical demands. (See Appendix V.)

Medical Practice in the Rehabilitation Center

Medical practice in the rehabilitation center varies considerably depending on to what degree the center is a comprehensive one or largely vocationally oriented. The medical aspects of an instrument designed to evaluate rehabilitation facilities suggests that a major portion of the medical evaluation may occur prior to the client's arrival at a rehabilitation center. (See Appendix VI.) Here the emphasis is placed on the collection and use of medical information, the degree to which it defines physical and environmental limitations, and its integration into the client's program. In this location all the medical evidence relative to the need for comprehensive vocational services may well have played some role in the decision to use such service or program. In many locales the availability of preadmission evaluation services may determine whether this had been accomplished. In some instances the need for comprehensive services may be readily apparent and in others the lack of comprehensive treatment services elsewhere in the community may dictate that the rehabilitation facility provide these. The need served by such facilities will largely determine the staffing patterns.

Depending on the comprehensiveness of the center, medical services may include acute intermittent care, treatment services of a restorative nature, interpretation and coordination of medical speciality services, and relating physical capacities to work evaluation and training. An analysis of the directory of Rehabilitation Facilities of the Association of Rehabilitation Centers gives some insight into the availability of medical services in these centers in relationship to the other components of adequate vocational assessment. (See Appendix VII.) The average full-time equivalents of each of the components in the rehabilitation center is strikingly similar to those of the medical center or hospital based facility. A perusal of staffing patterns in those centers where each of the professional disciplines representing each of the components is not present gives some insight into what degree several of the disciplines can reside in one of these representatives. While there is no evidence of substitution for medical services, in some instances these services are apparently minimal and sometimes appear to be provided by something less than a fraction of a full-time equivalent.

SOCIAL COMPONENT

The process of evaluating an individual for purposes of vocational rehabilitation requires cognizance of a wide variety of factors which may be conveniently labeled "social components." As with other components of evaluation, any attempt to assign relative values to isolated segments of a total person requires judgment, training, and experience. And like all elements of human judgment, there is no infallible rating scale to which the counselor may turn for a value figure on his client's attitude toward his family, or the change in his social outlook which may result from disability. These factors are important, and their importance is dynamic, but the degree to which they relate to the overall objective of restoring a disabled person to employment will always defy a rating scale.

Perhaps then, the social components of the rehabilitation evaluation are the most difficult to deal with since they require the exercise of more subjective judgment than the other factors. And perhaps because of this very difficulty there is an inclination to be less sensitive to an aspect of the client's total problem which may ultimately determine the success or failure of his rehabilitation plan. Enthusiasm to provide for the client's most urgent needs often leads to oversight of the obvious.

This is not to say that assessment of the other facets of his problem are always adequate at the expense of the social component, but rather that one feels more comfortable in relying on the physician's opinion or the psychologist's report. The counselor may feel better equipped to evaluate a work history than to determine the influence of a reversal of family roles. There are few tools to assist in the evaluation of social factors, and the few available are often not used.

Explicit rules are available for guidance in medical and psychological evaluation, and to a lesser degree, the vocational components. In a formalized evaluation setting, the services of a social worker are usually available to provide information about the social component. In such a setting, the information is gathered by home visit and client interview specifically devoted to the purpose. In effect the evaluation is done for the counselor by someone else. In the typical instance where evaluation must be performed outside of the institutional setting, or where social worker services are not available, the counselor must consider the social component as a part of his evaluation. The degree of competence among rehabilitation counselors to perform the social evaluation varies widely, but the necessity to consider social factors is constant.

Personal Data

Any evaluation of work potentials for a given individual must, of necessity include sufficient personal data for adequate identification purposes, as well as other personal information which might affect the applicant's vocational adjustment.

Identification information should include name, address, finding directions if no address is given, case number and/or social security number depending on agency policy, phone number and the names of family members who live with the applicant, as well as the names of immediate family members who live outside the home. Although it could be included elsewhere, the educational level and current earnings of the immediate family could be included under this heading.

A segment of information frequently overlooked is the type of associates a person has outside his own family. Does he attend church, play poker, spend most of his time at a bowling alley, attend sporting events? In such activities, with whom does he associate? How much time does he spend in reading? When he does read, what type of literature does he prefer? Could any of his friends or associates be of assistance in giving him leads or in helping him secure employment?

Home Conditions

It is a recognized fact that any individual's potentials for further success in any area of endeavor are materially influenced by the environment where he normally spends at least half of his time. It is, therefore, very important that the counselor have a clear and accurate picture of an applicant's home environment if an accurate evaluation of his vocational potentials is to be made.

First of all, information concerning the physical environment of an applicant's home is needed. For instance, is the home owned by the family, is it financed realistically, is it comfortable, in what section of the community is it located, are transportation facilities available, etc. All of these and other physical factors have important implications in forecasting an applicant's vocational success.

The relationship an applicant has with other family members may be very germane to an evaluation. If the group is a closely knit unit, the applicant may be reluctant to leave home for training or employment. In addition, other family members may contribute to or interfere with any plan, particularly if he is overly dependent or inclined to be guided by their wishes.

Under this heading, the client's cultural or sub-cultural level could be listed. Studies have shown, even in our modern society, a surprising number of individuals never rise above the occupational level of their parents. For instance: As a general rule, it is felt that an applicant's chances are enhanced for completing a college course when both his parents or a substantial number of his immediate family have completed a college course. The same could be said regarding parental accomplishments such as completing a trade school course or apprenticeship training program, etc. A certain culture or sub-culture does not automatically prevent an individual from rising to a level above it and at the same time, it does not guarantee success within it. The surroundings in which a person is reared do, however, exert strong influences on his future accomplishments.

Economic Factors

The economic status of an applicant, regardless of where it is placed in an evaluation, is very important since it quite often sets the limits for possible vocational planning.

First of all, the available resources must be known since one of the basic tenets of the vocational rehabilitation program is to provide those services which a client cannot conveniently provide for himself. Such information must be secured to determine the client's eligibility for services based on economic need. It is also necessary for other purposes. Since state rehabilitation agencies can only provide for a client's needs during the period when rehabilitation services are being provided, most rehabilitation plans would not be possible if some way could not be provided to care for the family of a client who has dependent family members. Such information should be verified from reliable sources.

In many instances, the client may have hidden or potential resources which could be tapped to help finance his rehabilitation plan. Examples would be life insurance policies with cash value, investment certificates such as stocks or bonds, friends or relatives who might be willing to lend or contribute funds. In the case of younger clients, scholarships should not be overlooked.

A very important point, not to be overlooked, is the financial liabilities a client or applicant may have. If a client is deeply in debt, a rehabilitation plan may be out of the question until the problem is resolved. Although the client may not have any assets or income to reduce his indebtedness, the emotional stress from such a situation might preclude any realistic rehabilitation plan. Knowledge of such conditions is a necessary part of any evaluation.

Sources of Information

The above information may be secured from a number of sources. Some of these are as follows:

1. Social agencies such as the Department of Public Welfare.
2. Business and/or work associates.
3. Professional people such as doctors, lawyers, etc.
4. Relatives.
5. School officials.
6. The interview with applicant.

SOCIAL WORKER'S ROLE IN A REHABILITATION CENTER*

The counselor should be able to call on the social worker for assistance as he does other disciplines, i.e., doctor, psychologist, psychiatrist, limb maker, educator, etc. He should feel free to ask social workers for an interpretation, from social (psycho-social) point of view, of family relationships, client's role in family, behavior, etc.

In case study, the social worker handles some of the same data as does the counselor, but with somewhat different focus. It is requested that the social worker participate in case study prior to presentation of the client for admission to the Center, in order (1) to include social worker's impressions and suggestions at admissions staffing and (2) to make initial social diagnosis and set tentative goals of casework service. Part of this participation is preparation of a social summary, not necessarily full social history, following interview(s) with parents and client, to include social worker's evaluation of:

> Client's personality and behavior dynamics.
>
> Client's role in family and immediate environment.
>
> Family structure, interrelationships, family dynamics, socio-economic level, aspirations for family members including client.
>
> Parent's interpretations of client's condition, i.e., when learned something different, cause attributed, efforts for treatment, feelings about results, impact of client's condition on family.

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* Developed by the Louisiana Division of Vocational Rehabilitation for use in that agency.

Preliminary assessment of areas in which social worker needs to work with family in order to enable family to help client move toward more mature social functioning, including employment.

Preliminary evaluation of client's assets on which to build and deficiencies which might be improved upon through social casework services.

FOCUS OF THE SOCIAL WORKER IN A CENTER*

Client

The social worker is expected to develop a plan of work which will enable him to have a series of interviews with each of the clients of the Center. The client may not initiate a request for casework help. It is expected that the social worker will have individual conferences, depending upon the needs of the client, (1) to know client better, (2) to establish a relationship with him, (3) to share with other staff in the Center appropriate information which will help in client's rehabilitation, (4) to recognize problems with which client and family need casework help, and (5) to anticipate client's reactions to stages in center program, so that client can be helped to face and handle stresses and obstacles.

In addition to individual interviews, social worker acts as discussion leader or moderator in group discussions. In the group discussions, the clients are able to share problems, to recognize that they are not alone with some of their problems, to develop more constructive approaches to problems, to control some unacceptable behavior, and to change some of their impressions. The group discussions serve, for some of the clients, as less threatening experiences than the individual conferences with the social worker. In addition, the responses of the peer group serve as strong influence toward more socially acceptable behavior.

Goals of the social worker include helping client to:

1. Express feelings.
2. Overcome or lessen fears.
3. Feel more secure in his relationships with others.
4. Develop better self-care and independence.
5. Make certain decisions for himself.
6. Build self-respect.
7. Build self-esteem.
8. Build dignity.
9. Understand his strengths and weaknesses.

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* Developed by the Louisiana Division of Vocational Rehabilitation for use in that agency.

10. Develop or reinforce sense of responsibility.
11. Cope with feelings of rejection.
12. Find acceptance in group.
13. Adjust to the program of the Center.
14. Set up realistic goals for himself.
15. Handle problems in relationships with family and others in immediate environment.
16. Build motivation, i.e., increase drive for achievement and sense of accomplishment.
17. Prepare for role of employee.

When there seems to be a need for services of other community agencies, or for additional Vocational Rehabilitation Services, social worker and counselor will discuss the problem presented and possible services needed and will decide together on method of handling and by whom referrals will be made to other agencies.

Parents and Family

The social worker will interview client's parents as part of the case study in preparation for presentation to the Admissions Committee. Both parents should be interviewed, together or separately, in order to obtain a better impression of family interrelationships and attitudes. This procedure also serves to involve both parents in client's rehabilitation program.

After client has been accepted, it is expected that the social worker will plan his work to include periodic conferences with one or both parents, for the purposes of (1) providing casework services which will enable him to reach a better understanding of client as a person, his strengths, weaknesses, and what he counts on or needs from them, (2) providing casework services which will help other family members with their own problems which may be interfering with client's personal and social adjustment, (3) assisting other family members to understand their role in Center's program with clients, and (4) preparing other family members for changes in client's behavior, expectations, and new role as potential employee - or helping the family to accept client's limitations if he is found to be unable to function in Center or be recommended for employment.

One aspect of casework with parents is the technique of group meetings with parents. Parents' visits to the Center serve as introduction to Center program and on-the-scene familiarity with Center activities and goals. Group discussions with social worker serving as leader or moderator enable parents to share ideas and feelings, to learn they are not alone with their problems and to find helpful suggestions. It is not intended that the social worker will help the parents to define their own role in client's rehabilitation program and to plan constructively.

The social worker's goals in working with parents include:

1. In relation to client:

a. Better understanding by family of client's problems, assets, limitations, and vocational potential.

b. Assistance from family to strengthen possibilities of vocational adjustment.

c. Interpretation to family of Center expectations of client, for reinforcement by family.

d. Change in family behavior or attitudes toward client, to enable client to function as more independent mature individual, with certain rights and responsibilities.

e. Help parents to adjust to changes in client's behavior.

2. In relation to parents:

a. Acceptance of parents as individuals of worth, dignity, who basically want to enable client to make more mature adult adjustment.

b. Assistance to parents in recognizing, expressing, examining, and clarifying their feelings and fears and help with handling these feelings and fears.

c. Recognition of parents' defenses (denial of problem, blame on others, false hopes, resentment, hopelessness) and guilt feelings. Assistance to parents in coping with current reality situation.

d. Assistance to parents with personal and social problems which, if improved, would facilitate client's rehabilitation. This would include referral to other agencies or facilities when indicated.

SOCIAL WORK CONCEPTS*

"Clients come to rehabilitation agencies out of the stresses of bodily defeat and impairment which threaten social functioning. They usually do not come for social or psychological help, but for physical restoration, speech and hearing therapy, vocational retraining, sheltered employment, etc. Often they find a large cast of professional helping persons. Helping persons sometimes entertain rescue fantasies which do not take into sufficient account the client's feelings, his readiness, his capacity, and his right to be actively involved in the helping process. A subtle system of rewards and punishment is often related to how passively and compliantly the role of patient is assumed. When the client encounters difficulty, the social worker may be called upon to enable him to utilize the services offered or to contribute understanding to the team toward the management of the patient. As social workers, we know intimately the resistances that underlie attitudes toward help, needing yet refusing it, wanting yet fearing it, requesting yet fighting it. Thus, the assessment of impaired motivation and skills in enabling are often key areas of our activity in rehabilitation.

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* Excerpts from an address by Florence Haselkorn, Assistant Professor, Adelphi Graduate School of Social Work, from the proceedings of a workshop on "The Practice of Social Work in Rehabilitation," June 20-26, 1960, sponsored by the Vocational Rehabilitation Administration.

Motivation is a complex phenomenon and involves the total personality. It has tangled and intertwined roots in physical, psychological, and socio-cultural determinants. Yesterday, you heard from Dr. Bisgyer about some of the psychological aspects of the stresses of disability and handicap and the ego's ways of coping. We know that, despite the severity of the reality stress of physical handicap, each person uniquely organizes his attitudes and perceptions toward common crises in life out of residues of his past experience. How the crisis is psychologically perceived will cast its shadow on motivation.

Socio-cultural determinants which affect motivation are sometimes overlooked or given casual consideration. We have tended to either outer or inner orientations. We sometimes seem to stand on our heads to avoid using common sense about stressful realities. At other times, we appear blinded to the unreasonableness in man's nature by our addiction to situational aspects. We have not yet been provided with an integrated theory of personality, but, in its absense, we must not lose sight of the interdependent and interacting nature of the variables in man's behavior."

"...Social role or role performance is the set of expected behaviors in certain defined situations. It results from personality factors as well as from social interactional processes. Roles are always reciprocal in nature and are not carried in isolation. A husband has a role with reciprocal expectations and responsibilities in relation to a wife, a father in relation to a child, an employee in relation to an employer, a patient in relation to a doctor, and a client in relation to a worker. To come closer to our concern, in rehabilitation we frequently meet our clients in transition between the roles of illness and wellness. Some experience difficulty in accepting the sickness role or handicap, others in accepting the wellness role or residual areas of health and functioning. The assessment of role performance of our client as a patient helps us to sharpen focus and to partialize treatment goals as helping him carry an appropriate role as a patient in relation to his rehabilitation program.

Illness or handicap can be perceived as a role which sanctions increased expectations from others and decreased obligations toward others. The ascribed role behavior of a patient to his family permits some dependency and abandonment of previous role. The role of the patient in relation to a doctor carries connotation of submission to authority. Perceptions of the role of the helping person, whether it is doctor or caseworker, are often laden with distortions. The helping person may be perceived as omnipotent, able to perform magical cures, or as a depriving punishing authority, demanding submission, obsequious gratitude, and threatening annihilation. He may be perceived not as a benefactor, but rather as the target of resentment and anger. Feelings of worthlessness, sense of social inferiority, sense of helplessness, and powerful dependency, needs are often confirmed by the implicit demands of the patient or client role. Needing help from others can threaten one's sense of adequacy, heighten one's sense of failure. To cope with these threats to personal integrity, a whole reportory of protective mechanisms are called into play, some adaptive, some maladaptive. We can help to reduce some of the maladaptive defenses by our responsiveness to the underlying feelings aroused by the demands of the patient role."

"...When one views the family as a system of interdependent relationships, it follows that any change in one member triggers reactive responses in other significant persons with whom he interacts. We sometimes see this dramatically demonstrated when one family member develops physical or psychological illness as another becomes well. It follows that, for some situations, the focus of treatment becomes the total family unit, in efforts to realign and restructure family relationships. Out of the recognition of the dynamics of family interaction have come such developments as joint interviews. This is new only in the conscious and more knowledgeable way in which it is being utilized. Joint interviews provide valuable clues to personality interaction not available to us through the patient's eyes. Are there values for the clients themselves in joint interviews, in reducing distortion and projection, increasing communication by bringing problems out in the open, in modifying mutual expectations?"

"The pitfalls, of course, are the danger of routine conveyer belt screening, superficial assessment which becomes a ritual, and the fact that it may limit our carrying cases in on-going treatment. I am afraid that, for some time to come, we will continue to have to make choices of whom we serve. Be we have a responsibility here. What determines our priorities? Is it the urgency of need? Then how is this determined? Is it treatability? Can we limit service to those with sufficient capacity to utilize help in our traditional ways? Is it social cost, those patients who more than others affect more people in their environment and are the carriers of social disturbances? In rehabilitation agencies, do we as social workers serve primarily those persons whose psycho-social problems bear directly on the immediate task and use other resources in the community for less directly related problems?

There are few rules to guide us and priorities will vary from setting to setting. It is important that we not operate in a haphazard way and that we continuously subject our practice to critical examination. When existing patterns, transplanted from other social work settings, seem maladaptive in new settings, we must be flexible and ready to search for new approaches. One possibility that suggests itself, but cannot be dealt with here, is the role of the social worker as consultant. Where needs are greater than can be fulfilled by direct casework service, or where this for some reason is not the treatment of choice, and where we work in close collaboration with what Dr. Gerald Kaplan calls the caretaking agents (doctors, nurses, teachers, employers), we can infuse some of our understanding through indirect means. We do not need to bear the formal title of consultant to carry this role and we are engaged in it more often than we are aware."

SUGGESTED OUTLINE OF SOCIAL FACTORS*

1. FAMILY COMPOSITION AND RELATIONSHIPS:

   a. Number in family.
   b. Client's place in family, relative position.
   c. Family attitude about client's disability.
   d. Special relationship with other member.
   e. Level of education in family.
   f. Ambition of family for client.
   g. Level of employment in family.
   h. Client's attitude toward family - or other member.
   i. Ability of family to help in vocational plan.

2. ECONOMIC SITUATION:

   a. Source and amount of income.
   b. Adequacy of income.
   c. Adequacy of financial management.
   d. Other possible sources of income.
   e. Estimate of needed income for future.

3. SOCIAL COMPETENCE:

   a. Relationship on a level consistent or not consistent with chronological age.
   b. Social activities purposeful or useful or not purposeful or useful.
   c. Behavior - in conformity to social standards at school and community in general.
   d. Responsibility.
   e. Ability to function away from family - independent.
   f. Lack of normal developmental opportunities.
   g. Relationships in school - with other students and teachers.
   h. Grooming and personal habits.
   i. Travel alone - use public transportation.
   j. Ability to carry on a conversation.

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* Adapted from an instrument designed to evaluate rehabilitation facilities.

PSYCHOLOGICAL COMPONENT

This discussion will be concerned with psychological information the vocational rehabilitation counselor secures in order to make a more adequate assessment of a client's vocational or rehabilitation potential. As previously pointed out by committee members in this collection of material, the many factors involved in a comprehensive evaluation cannot be isolated or separated except for discussion purposes. When such an arbitrary division is made, we find it difficult to discuss psychological factors without an occasional reference to other components of the evaluation (medical, social, educational and vocational).

During the past few years, much progress has been made in developing ways and means of securing psychological information. Through academic training and experience, counselors have increased their skills in using the interview and the case study method for securing information. They have likewise become more sophisticated in the use of psychometric instruments. An increasing number of qualified psychiatrists and psychologists have become available for the evaluation of clients requiring skills outside the counselor's area of competence. Furthermore, there is no dearth of information and guidelines for securing psychological information. Di Michael, in a pamphlet, entitled "Psychological Services in Vocational Rehabilitation",[1] lists some of the values of psychological evaluation to the client. In addition, he gives a comprehensive discussion of ways and means for securing psychological services. The material in Appendix VIII is an example of how one state agency (Oklahoma) adapted Di Michael's material along with information from other sources for a section of their casework manual to be used for providing psychological services.

After the psychological information is secured, it should be used in formulating the client's rehabilitation plan. We frequently hear supervisors say that their counselors do a good job of gathering psychological information but fail to give it due consideration in the final rehabilitation plan. In the publication, "An Introduction to the Rehabilitation Process" edited by John F. McGowan,[2] the statement is made that, "Evaluation involves more than mere psychological testing. It includes the study of the client's past behavior as well as conclusions drawn from observations of his current behavior during the initial interview and outside contacts. The evaluation of the client's behavior is in no way limited to the preliminary phase of the study but continues during the entire rehabilitation process."

In a similar vein, Super and Crites observe that, "In most contemporary thinking, appraisal, and counseling are viewed as essential to a program of vocational guidance, and so is exploration. The effective vocational counselor is one who knows when and how to use appraisal techniques, when and how to rely primarily on counseling, and when and how to help the counselee engage in activities which will help him to obtain the insights and information needed."[3]

The amount of psychological information and other psychological services will depend on the individual case but after it is secured, due consideration should be given to it in the final analysis or evaluation.

In making a vocational assessment of any applicant or in planning a rehabilitation program for an applicant, it is imperative that psychological factors be considered. In fact, it is necessary, whether a client's major disability is a physical or a mental condition. It is common knowledge that a majority of failures on jobs are due to psychological factors rather than an inability to perform the essential operations of the job itself. Although a client's or an applicant's problem may be primarily physical, any service which could be rendered might fail to restore or prepare him for employment if the psychological factors are overlooked or not given sufficient consideration.

Native Ability

Perhaps the first thing we look for in "sizing a person up" as a potential friend, business associate, employee, or in assessing his employment potentials is, the amount of native ability, intelligence, level of intellectual functioning, degree of brightness or whatever we choose to call it. The ability to cope with his environment sets the top limit of any plan we may have in mind for the individual under consideration.

One measure for native ability is the grade level a person achieved in formal schooling, since the levels of intelligence usually tend to correspond roughly with the grade level achieved in school. This, of course, is based on the assumption that the individual had ample opportunity to attend school.

Another method which should ordinarily be used to supplement other less objective measures is an appropriate psychometric instrument. The type of instrument (individual or group) should be determined by the emotional condition, achieved school and level and the nature of the applicant's disability.

The counselor's assessment of the applicant's level of intellectual functioning based on the interview, behavior during tests, and on information he has secured should be given considerable weight in judging a prospective client's actual level of intellectual functioning.

In any evaluation of a client's native ability and how he uses it, his past work experience should not be overlooked. The fact that a person has never held a job above an unskilled level will have implications for assessing his future vocational potential.

Interests, Aptitudes, and Special Abilities

Some of the same criteria for judging an individual's level of intellectual functioning can be used in assessing this particular area of his vocational potential. The following are particularly valuable:

1. Client's own statements.
2. Appropriate psychometric instruments.
3. Job try-out.
4. Employment history (full or part-time).
5. Statements of former employers, family members, teachers, friends, etc.

Personality Traits

As previously indicated, an individual's personality traits may be the most important set of factors in making a prognosis for future vocational adjustments. It is very difficult and often impossible to make an accurate assessment of these intangibles.

An effort should be made, however, to identify the individual's strengths and weaknesses in this area. In other words, from whatever sources are available, it is important to identify those traits which will be an asset to him, as well as any which might preclude or hinder vocational adjustment. Efforts should be made to utilize his strengths and to circumvent or avoid those which would hinder him.

Emotional Stability

It is common knowledge that there is a direct relationship between an individual's emotional stability and the types of employment which he may successfully pursue. Of particular importance is how he reacts to stress situations. It is also common knowledge that individuals, who break down, panic, or lose their composure cannot follow certain occupations.

Motivation

This, above all others, is the one factor which should be thoroughly investigated in any evaluation. Although it is an intangible trait, every effort should be made to see if the client is sincerely interested in helping himself. It is not enough to ascertain that he merely wants to become self-supporting. The question to be answered is, is he willing to make the necessary effort and sacrifices to achieve such a goal?

Perseverance and Dependability

These are also intangibles which are difficult to pin-point or assess. Their elusiveness does not, however, detract from their importance.

Methods of Assessment

The above factors although elusive and intangible, can be evaluated by utilizing the following:

1. The counselor's impressions.
2. Reports from social agencies.
3. Reports from individuals.
4. Opinions of family members.
5. Psychological and/or psychiatric clinical evaluation when indicated.

EDUCATION AND WORK EXPERIENCE COMPONENT

It has been mentioned earlier in this material that classification of evaluative activities in separate components may be acceptable for study purposes but that, in practice, they are but aspects of a single process. It seems appropriate to recall this point in connection with the subject matter of this topic. It is a common practice to include the educational data concerning a client with the psychological information. This practice is particularly justifiable if we include in education the learned attitudes and emotional concomitants of educational experience. Work experience is ordinarily investigated and recorded as a separate unit of information concerning the individual. A simple "work history" may appear to lend itself well to this separate consideration. When work habits, interactions with fellow workers, and motivational characteristics are included in this consideration, delineation as separate components becomes less apparent.

Educational Factors

For purposes of this discussion, the educational considerations will be limited to those things that are rather directly related to academic achievement. Other aspects of the problem have been discussed in some depth elsewhere in this material.

It is common knowledge that grade placement is meaningless as an index of educational achievement. Employment practices have given it some occupational significance out of proportion to its educational meaning. Some employers include a high school diploma among the conditions of employment by them. Legal requirements sometimes stipulate that an eighth or tenth grade "education" is prerequisite for admission to certain accredited vocational schools. The educational demands of recent technological advances have tended to further emphasize grade placement as a measure of educational proficiency. This single index may be quite adequate for those persons who have established work records or have clear potential for areas of occupational endeavor. In the course of undertaking the evaluation of those individuals whose work records are limited or whose limitations are severe and complex, we must examine educational achievement in greater depth.

Educational achievement testing is well standardized. In the Section on the Psychological Component a number of the most successfully used tests of this kind are listed. These tests provide quite dependable indices of individual performance in various subject matter fields. Some of these tests may afford some clues as to the degree the individual is able to apply these educational achievements to problem solving and performance. For the most part, the description of this last factor may have to depend on subjective evaluation of observed behavior.

Since the evaluation is directed toward a measure of vocational potential, particular attention should be given to the learned knowledge and skills that may be applicable to performance in specific occupational activities. Identification of any such achievements of the individual is incomplete unless the degree of competence in each is a part of the information gathered.

In those situations where an intensive evaluation is needed, certainly consideration should be given to the possibility of casual learning experiences that may be significant. Reading habits, hobbies, recreational inclinations, social activities and the like can well result in development of knowledge and skills that are occupationally significant. Many times the individual will fail to identify the results of these activities as a part of his educational achievement.

If possible, the character of study habits and skills in learning should be identified. Techniques for objective measure of this factor are limited. Some clues may be furnished by comparison of achievement scores with psychological data. Some school records are complete enough to give some of this information. This too, may have to be a subjective judgment on the basis of information revealed by the client's responses in an interview. This matter of study habits and attitudes may be a quite critical factor in the evaluation of the person with complex problems. It could be the critical index of potential for further education. In turn, further educational achievement could be so significant as to determine whether or not a given individual would have any rehabilitation potential.

School records sometimes include identification of extra-curricular interests and activities of the individual. Much of this type of information is easily secured in informational interviews. Some school records include information on the individual's interaction with peers and authority figures. Where interviews with school personnel are possible, this information can often be secured in satisfying detail. Data from these aspects of educational experience can be quite revealing in the psychological appraisal of the client.

Any intensive investigation of educational experience will likely reveal the educational aspiration of the individual. The educational level of his immediate family and the general cultural environment in which he lives should become apparent. Surely the client will reveal the degree and kind of satisfaction that he derives from educational achievement. Such data could be quite significant vocationally and would certainly furnish material pertinent to psychological appraisal.

Work Experience Factors

Most of our early work in the area of selecting job objectives was based on the principle of gross matching of patterns of occupational skills and experience with descriptions of job requirements. This presumed a reasonable degree of uniformity and some stability of basic occupations throughout business and industry. This basic procedure probably remains effective for many candidates for rehabilitation services. It is suggested that rapidly changing technology may make this approach less effective than it once was. Rehabilitation's concern with the more severely limited may necessitate some refinement of our techniques.

With those individuals whose occupational problems are severe, care and thoroughness in the preparation of a work history becomes a prime necessity. Simple listing of job titles, dates, and name of employer is not adequate. The characteristics of this work record should be determined and recorded. Such items as the character of job tenure and the explanations for these characteristics should be identified and recorded. It is important to know at what level of responsibility and skill the individual was functioning. The reasons for his functioning at the level identified should be determined. If it can be determined, the reasons for the individual's engagement in his occupational endeavor could be significant. In the course of soliciting from the client this work history, one may also discover clues as to work habits and attitudes.

Many severely disabled individuals have limited work records. In these cases casual work experience, carefully investigated, becomes increasingly important. Avocational interests and pursuits can reveal much occupational potential. This can be dramatically critical with that individual who finds his established field of endeavor closed to him because of the onset of a disabling condition. This area of experience should be investigated with the same diligence as any work record.

The individual's reporting and interpretation of his work record can often be biased. With those persons who have suffered severe defeat, the bias may not be in his favor. It is on this basis that we can justify the review of this work record with former employers and fellow workers. These interpretations may be biased in terms of the objectives of the employer or the prejudices of the fellow worker. Yet, from these different points of view we may synthesize a more objective appraisal that is useful in our counseling with the client.

The psychological gestalt of the individual may be incomplete until his attitudes toward occupational endeavor have been identified. What is his aspirational level occupationally? What are the expectations of those immediately associated with him? The occupational pattern of the community or other environment in which he lives or expects to live may have a significant bearing on his vocational potential. The level of income necessary to support the client's established mode of living must be taken into account in long range vocational planning.

Another area of work experience that is becoming increasingly important is that of the client's insight into the world of work. Regardless of the adequacy of the individual's understanding of his potential and aspirations, he could be completely frustrated by limited understanding of the opportunities afforded by our economy. This aspect of the client's total work experience must be investigated. The assessment that affords a basis for counseling with him in incomplete without it.

A unique approach to the investigation of the work experience factors has been developed by Ray Ziegler of the Oregon Bureau of Labor.[4] He has devised a scheme for individual self appraisal that could well be adapted to the counselor's appraisal of the client. It is an effort to identify all specific skills, capacities and interests without regard to occupational patterns.

In this technique, the indvidual is asked to list, in written form, his responses to six questions. The questions are so designed that they elicit more that is usually thought to be occupationally significant. The responder is asked to suspend all evaluation in terms of jobs while preparing the inventory.[5]

Once the inventory is complete, the list is then analyzed to synthesize it into an occupational pattern. Ziegler proposes that this synthesis be developed into a resume. This phase of the development of occupational potential requires extensive knowledge of job demands and occupational information. Many clients will require assistance in this endeavor. Changing technology is making it increasingly difficult to keep our body of occupational information adequate for this purpose.

Leo Goldman[6] reviews the current thinking concerning this process of predicting occupational success from the data gathered concerning a client's qualifications. In his discussion, he considers "vocational" to be all of those personal and social characteristics that bear upon successful employment. This probably most appropriate in that research has demonstrated clearly that personal and social traits are the major determining factors in job success. Acceptance of this evidence does not lessen the need for investigation of the factors that we have discussed here. Personal adjustment may determine the potential for successful employment, but educational and experience factors may identify the focus of the effort.

FACTORS RELATED TO AN ADEQUATE VOCATIONAL ASSESSMENT

After all of the components have been identified, the evaluation is not complete until they have been related to other factors such as occupational information. If a client meets all the requirements for a particular job or vocation, or if he can be trained for such a vocation, a job must be available and there must be some assurance that the job will not disappear within the immediate future.

If the evaluation indicates that physical restoration and/or training is needed, facilities must be available. In addition, if all needed facilities are available, the counselor must have access to funds to pay for them.

The counselor must also take into consideration the quota and caseload requirements of his agency.

All of the preceding, therefore, must be weighed by the counselor when he makes a professional judgment as to whether an individual applicant should be accepted for vocational rehabilitation services. Especially, the factors listed in this paragraph must be considered in deciding whether there is reasonable assurance that a client can be prepared for, or returned to, remunerative employment.

THE SUMMARY OF DIAGNOSTIC EVALUATION

The mere collection of information regarding a client (medical, social, psychological, educational and vocational) is meaningless and serves no useful purpose unless it is evaluated and utilized for the purpose for which it is intended. After the appropriate information on an individual has been collected, it must be evaluated by a competent person. Since, in most State

Agencies, the primary responsibility for determining whether a case is accepted for rehabilitation services is delegated to the rehabilitation counselor, he is the professional person who makes the evaluation.

The evaluation involves the integration and bringing together all of the significant information concerning the client into a meaningful pattern or gestalt. Williamson defines this synthesis as follows:

> "The making of a diagnosis is a process in logical thinking or the 'teasing out' from a mass of relevant and irrelevant facts, of a consistent pattern of meaning and an understanding of the student's assets and liabilities, together with a prognosis or judgment of the significance of this pattern for future adjustments to be made by the student."[7]

When a potential client is referred for vocational rehabilitation services, the counselor begins to make tentative appraisals and vocational diagnosis. As the casework proceeds and additional information is secured, previous impressions, diagnosis or evaluations may be revised or discarded and many new ones are made before the counselor:

1. Establishes eligibility.
2. Helps the client select an appropriate job objective.
3. Determines what services are needed to enable client to reach his objective.
4. Makes a plan to provide for the needed services, or
5. Determines that the client's vocational potentials do not warrant vocational rehabilitation services.

In other words, the counselor must look ahead and synthesize the situation many times during the diagnostic or evaluation period.

To recapitulate, the counselor secures information concerning the basic components of vocational assessment from the interview, school, medical and employment records. In addition, further information may be secured from psychological tests or evaluations and from various other sources. His evaluation or diagnosis, however, is correct only to the extent that he has skills to use and interpret the data and only to the extent that he secures and considers all of the significant and relevant data. If psychological tests are not administered and interpreted correctly and if medical data or opinions are not taken into account, his diagnosis will be faulty. If he fails to consider school grades, personality traits and client motivation, his evaluation will, likewise, fall short of the target. It is important that the data be accurate, that it be secured in the right way and be correctly analyzed. It is also important that each bit of data be seen in its proper perspective with regard to the total pattern. After the diagnosis is made, the counselor must interpret it to the client if it is to be of any benefit to him.

What is the nature of the synthesis the counselor must make? After the mass of information has been collected, he must select portions which are relevant and significant to the vocational diagnosis and integrate them into a meaningful pattern as previously stressed.

Williamson[8] and Wren[9] both emphasize that this integration is not a mere additive process. The counselor must use his professional judgment in putting the parts together in order to arrive at a final evaluation.

The following additional basic principles or guidelines are suggested for making a vocational assessment:

1. Secure as much information as possible and practical. Incomplete information can result in erroneous conclusions.
2. Favorable and unfavorable information such as high and low test scores should receive special attention.
3. Consider personality traits as well as environmental factors, family background, attitudes and motivation.
4. Consider each fact in relation to other data and not by itself, alone. The counselor's professional judgment comes into play in the evaluation of interrelationships between bits of data and in understanding them as a dynamic whole.
5. Weigh and check bits of information against each other. Inaccuracies can be elimintated in this manner. Differences among different bits of information should be resolved before they are used.
6. Take into account the reliability of each item of information before it is used.
7. Obviously, it is not possible to use all information but in the early stage of a diagnostic evaluation, the counselor cannot always be sure what is significant. It may, therefore, be a mistake to neglect information which may be significant.

WHAT IS AN ADEQUATE EVALUATION?

What is an adequate evaluation? This is an important question because State and Federal regulations require that an "adequate" evaluation be made of each individual case. It is essential to understand the individual's assets and liabilities and to formulate a realistic plan.

One question which arises - "adequate according to what?" It seems obvious if we are to assess "adequacy" we must have standards by which to measure. If we agree that standards are necessary to assess adequacy - What are these standards? Where are they to be found? Are there any standards which are recognized throughout the United States?

Evaluation Standards

The logical starting point in the search for a definition of adequacy is the Law and the Regulations. Public Law 565 does not define adequate evaluation but Section 401.15 of the Regulations does throw some light on the subject. Subsections (a), (c), and (d) treat primarily with the medical; while subsection (d) specifies psychological, social, and vocational information which is essential.

Section 401.15 of the Regulations and Chapter 4 of the VRA Manual both describe the type of diagnostic data which is required by the State Plan. Despite these guidelines (or standards) some degree of subjectivity enters into the assessment of the "adequacy" of evaluation. For example, Section 9.2 of the State Plan Guide states: "Indicate that, in each case according to the degree necessary, the diagnostic study will include an evaluation of the individual's personality, intelligence level, educational achievements, ...etc." The key words are "according to the degree necessary."

How is the rehabilitation counselor to know the amount (degree) of psychological data or vocational data which is essential? One answer might be that he should obtain whatever information he will need to establish eligibility and formulate a plan, but this may seem vague to the counselor.

Are there other recognized or accepted standards? Fortunately there are standards for medical and psychological evaluation which are explicit. Social and vocational factors are not as well defined. VRA Manual Chapter 16, "Case Study and Diagnosis", includes "Standards of Medical Diagnosis" but does not include standards for psychological, social, and vocational evaluation.

Probably the most authoritative and accepted guide for psychological evaluation is the VRA bulletin, "Psychological Services in Vocational Rehabilitation." The section entitled "Standards in Selecting Clients for Psychological Evaluations," identifies handicapped individuals who need psychological evaluation and those who may not. For example, psychological testing is needed when: "Long-term or expensive training is involved." Psychological evaluation may not necessarily be required when: "The person has recently been successfully employed and intends to return to work as soon as physical restoration services have been rendered." "Standards in Selecting Clients for Psychological Evaluations" has been generally accepted by State agencies, and some agencies incorporate these standards in their casework manual.

Two sources of information about evaluation in general are the VRA publications: "Casework Performance in Vocational Rehabilitation" and "An Introduction to the Vocational Rehabilitation Process." These bulletins cover the medical, psychological, social, and vocational components and are especially valuable because they include a comprehensive description of social and vocational factors which are not included in the VRA Manual.

One of the most important elements of an adequate evaluation is what is sometimes referred to as the "rehabilitation diagnosis." "Casework Performance in Vocational Rehabilitation" describes the appraisal of all the data this way:

> "Rehabilitation diagnosis in essence refers to evaluation and summarization of all available pertinent data for the purposes of establishing eligibility, and pointing up the major needs and problems of the client. The counselor should have the analytical ability to separate relevant from irrelevant data, to consider each factor in relation to the whole, and to synthesize the substantial facts into a meaningful pattern."

Thus far, we have identified standards which appear in publications circulated nationally. In addition, many states have developed standards which are incorporated in their casework manuals. Some of these may be superior because they are more comprehensive. VRA Regulations and the Manual merely set forth minimum requirements.

Attempts to Measure Adequacy

One advantage in having written standards is that staff members are more likely to do an adequate job if they know what is expected. Standards of performance exist whether they are written or not. Sometimes they are merely in the mind of the supervisor but written standards help everyone agree on what should be done.

To determine whether standards are being observed some method of measuring performance is necessary. Probably the most common method is the "review schedule." VRA has developed several review schedules, the old GTP Workshop group developed a review schedule, and many states have developed their own.

An example of the review schedules which have been used are included as Appendix IX. It is a "Check List" specifically designed to appraise the adequacy of rehabilitation evaluation.

It is doubtful that any review schedule yet developed is ideal. Most have serious shortcomings and none of these schedules have been subjected to rigorous field testing to determine validity.

It is possible that an experienced rehabilitation staff could develop a review schedule with a high degree of validity. A university might sponsor such a project with support from VRA. Each item of the schedule and instructions could be carefully tested so that results would be comparable no matter who used the instrument. The field testing procedure might be similar to that used in standardizing psychological tests.

Despite all of their imperfections, review schedules are a valuable tool in revealing weaknesses and the need for staff development.

Upgrading Evaluation

State agencies as well as rehabilitation counselors and supervisors may need to appraise their evaluation methods.

In recent years more comprehensive or sophisticated techniques of evaluation have come into use throughout the country. Rehabilitation centers, speech and hearing centers, amputee clinics, sheltered workshops, cardiac evaluation units, optical aid clinics, half-way houses, and adjustment training facilities are all being used for evaluation purposes. These facilities contribute essential information which often makes the difference between success and failure.

There is a wide variation in the use of evaluation facilities, however. To illustrate different practices or "levels" of evaluation: Some states accept audiological examinations administered by hearing aid salesmen in lieu of a specialty examination. Others require an otological examination while others require an evaluation at a speech and hearing center.

State agencies may need to take stock of current practices in evaluation, facilities available, and the use which is being made of facilities. Some inventory or check list such as the one included in Appendix X might be used to aid in this study.

Conclusions

1. The problem of determining what is an adequate amount of information for evaluation purposes is stated succinctly in the VRA bulletin, "Casework Performance in Vocational Rehabilitation."

"Obviously, since each client presents different problems, the amount of information needed within each of these areas (medical, psychological, social, and vocational) will vary widely from case to case. For example, in some cases, eligibility is easily and quickly established, while in others much study may be necessary. In some cases, the selection of a vocational objective may be difficult but not in others."

2. Evaluation is a complex subject - probably as complicated as any subject in rehabilitation. It may not be possible to reduce it to a simple formula, but the counselor needs to know where he can get authoritative information.

3. Written standards and review schedules or check lists appear to be useful tools in upgrading evaluation.

4. This paper is concerned with evaluation methods used by a rehabilitation counselor - not those of a rehabilitation center. It is recognized that there are useful techniques, such as job-sample-evaluation and team-evaluation which may be included in a rehabilitation center.

5. Evaluation facilities (of all types) should be utilized when their use will contribute to a more complete evaluation of the individual.

A SUGGESTED GUIDE FOR STUDY OF THE EVALUATIVE PROCESS

A. Medical Components
    1. Identification of impairment and limitations.
    a) Expressed in anatomical or pathological terms.
    b) Prognosis for removal or amelioration of impairments.
    c) Functional limitations.
    d) Activities to be avoided.
    e) Remaining physical, mental, and emotional capacities as compared to a normal person.

2. Reports
    a) Above spelled out on forms or in narrative form on understanding level of counselor.
    b) Specific recommendations regarding need for further diagnostic study.

B. Social Components
1. Home conditions
    a) Physical environment.
    b) Relationship with other members.
    c) Cultural and subcultural level.

2. Personal data
    a) Identification information.
    b) Personal habits.
    c) Associates.

3. Economic factors
    a) Available resources.
    b) Potential resources.
    c) Liabilities.

4. Attitudes
    a) Toward self (self-image).
    b) Toward problem or problems.
    c) Toward family.
    d) Toward work.

5. Sources for securing above information.
    a) Social agencies.
    b) Business or work associates.
    c) Doctors.
    d) Relatives.
    e) School officials.
    f) Counselor's impressions.

C. Psychological Components
1. Native ability
    a) Assessed by:
        (1) Appropriate psychometric measurements.
        (2) Counselor's assessment.
        (3) Previous history.
2. Interests, aptitudes and abilities
    a) Assessed by:
        (1) Client's statements.
        (2) Appropriate psychometric instruments.
        (3) Job try-out.
        (4) Work history, hobbies, etc.
        (5) Counselor's assessment.
        (6) Statements of former employers.

3. Personality traits
    a) Strengths and weaknesses.
    b) Emotional stability.
    c) Reaction to stress.
    d) Motivation.
    e) Perserverance, dependability, frustration, tolerance, etc.
    f) Above traits assessed by:
        (1) Counselor's impression.
        (2) Reports from social agencies.
        (3) Reports from individuals.
        (4) Clinical evaluation where indicated.

D. Educational and Vocational Components
1. Educational background
    a) Achievement level.
    b) School record.
    c) Preferred subjects.
    d) Extra-curricular activities.
    e) Behavior problems.
    f) Educational plans and ambitions.
    g) Additional formal training.
    h) Educational level of immediate family.
2. Vocational factors
    a) Work history.
        (1) Job tenure.
        (2) Types of jobs held.
        (3) Levels of responsibility.
    b) Work habits and attitudes.
    c) Opinions of former employers and co-workers.
    d) Aspirational level.
    e) Membership in professional or trade organizations.
    f) Previous wages or salary.
    g) Part-time experience.
    h) Occupational level of immediate family.
    i) Attitude of family members.
3. Occupational information
    a) Available jobs.
    b) Long term outlook.

E. Factors Related to An Adequate Vocational Assessment
1. Available resources
    a) Training.
    b) Physical Restoration.
    c) Funds.
2. Quota and caseload requirements.

F. Summary or Diagnostic Evaluation Made by Counselor

[1] Di Michael, S. G. *Psychological Services in Vocational Rehabilitation*. U. S. Department of Health, Education, and Welfare, Office of Vocational Rehabilitation, 1959.

[2] McGowan, J. F. (Ed). *An Introduction to the Rehabilitation Process*. U. S. Department of Health, Education, and Welfare, Office of Vocational Rehabilitation, 1960, page 66.

[3] Super, D. G. and Crites, F. O. *Appraising Vocational Fitness*. New York: Harper and Row, 1961, page 14.

[4] Ray Ziegler, Director, Senior Work Division, Oregon Bureau of Labor, Portland, Oregon.

[5] Ziegler, Ray. *Teaching Creative Job Searching Techniques*. (Unpublished pamphlet) Oregon Bureau of Labor, Portland, Oregon.

[6] Goldman, Leo. "The Process of Vocational Assessment", Chapter XVII of Borow, Henry (Ed). *Man in a World at Work*. Houghton Mifflin Co., Boston, 1964.

[7] Williamson, E. G. *Counseling Adolescents*. New York: McGraw Hill, 1950, page 179.

[8] Williamson, op.cit., page 178.

[9] Wrenn, Gilbert C. *Student Personnel Work in College*. New York: The Ronald Press, 1951, page 115.

SECTION B

GUIDELINES FOR SELECTION OF CLIENTS FOR FORMALIZED (FACILITY) EVALUATION

DEFINITIONS

The divergent concepts and varying evaluation practices and techniques employed in the states represented within the Study Group made it necessary early in the deliberations and explorations to establish definitions upon which the group could agree before the assigned charge could be dealt with effectively and constructively. The following definitions were established and served as the operational guide in attending to the charge "To develop guidelines for the selection of clients for formalized (facility) evaluation." Agreement or uniformity of opinion relative to the nature of the evaluation process was never reached. Points of disagreement centered primarily on: Is the evaluation process purely a diagnostic procedure or is it a "service" procedure with diagnostic implications, i.e., is it a short-term process directed toward the compilation and interpretation of findings on which predictions relative to the individual's vocational potential can be based or is it a process whereby certain conditions or variables designed to effect change within the individual are employed over a longer period of time and in which subsequent analysis of the changes effected constitute the evaluation.

"Formal" Evaluation

The term "formal" is used to differentiate between a service which is evaluative, both in orientation and objective, as opposed to observations and investigations, incidental to services other than evaluation per se. "Formal" further implies that the evaluation process is an organized, systematized, supervised procedure, coordinated and conducted by professional personnel whose basic skills, philosophies and concepts are evaluative in nature. The term further suggests the employment of established and tried methods of collecting, interpreting and analyzing predictive data through a process which is culminated in a staffing or conference which finalizes, interprets, and integrates the collected data in the preparation of meaningful, practical and definitive recommendations relative to the evaluatee's employability, feasibility for further services, or services necessary to realize his ultimate employment, if recommended.

"Facility" Evaluation

The comprehensive rehabilitation facility evaluation process commonly includes all or any combination of the following, depending upon the objective of the agency or facility:

Evaluation of:

a. physical capacities
b. learning ability
c. aptitude and specific skill potential
d. ability to achieve and maintain adequate social relationships
e. ability to meet demands of conditions of work, e.g., repetitive operations, pressures of production quotas, noise, etc.

During this process the object is to evaluate "the whole person" and to involve him actively. Our usage of the term "evaluation" implies the utilization, in addition to the standard physical, psychological, and vocational techniques of individual appraisal, of either real or simulated work activities (job sample, workshops, job tryout, trial training, trial employment) designed to elicit behavior relative to potential for employment.

INTRODUCTION

Few of the many services involved in, or related to, the total rehabilitation process have received as much attention in recent years as has "evaluation". Unfortunately, however, very little in the way of concise, definitive and useful information regarding the utilization of "formal, facility evaluation" has been developed. The establishment of specialty and comprehensive rehabilitation facilities throughout the country over the last decade has unquestionably expanded the professional armamentarium of the rehabilitation counselor but has, paradoxically, necessitated the use of judgments and decision-making regarding the utilization of evaluation services without offering much more than a re-emphasis on his need for omniscience. In most instances, the information available is either directed toward answering the "how" or the "why" of evaluation, concerns itself with theoretical or philosophical concepts, or champions certain techniques or approaches and the rehabilitation counselor, unless he is a member of the parent agency or affiliated with the facility, is left to his own devices to gather information on which to guide his decisions and base his judgments in utilizing this service.

Guidelines cannot replace the Counselor's responsibility for familiarizing himself with the facilities and resources available to him and their proper utilization; however, they can be a helpful assist in deciding "when" and "why" to refer a client to a facility for formal evaluation.

The Study Group, while recognizing that a plethora of factors might conceivably influence a decision to utilize formal, facility evaluation services, established several general guidelines which were believed to be applicable to any process in which the appraisal of vocational potential is a factor.

GUIDELINES

(1) When the appropriate diagnostic facilities (medical, psychiatric, psychological, speech and hearing, etc.) are not available in the client's home community, nor conveniently accessible.

(2) When the client has a "global" disability (such as cerebral palsy) or multi-disabilities, which affects his functioning in all, or most of the vocationally significant dimensions (physical strength and stability, ambulation, hand-eye coordination, manipulative dexterity, intellectual) to the extent that careful, detailed exploration and study is necessary to determine realistic objectives within the restricted field of vocational choices imposed by the multiple limitations. (See Appendix XII for the type clients referred to one comprehensive center facility for evaluation during 1964.)

(3) When a special living situation or supportive services are necessary to properly conduct an adequate evaluation, e.g., paraplegia, quadriplegia, epilepsy, or any disorder which dictates the need for assistive, supportive or supervisory care during the evaluation period.

(4) When the nature of the disability is such (deaf, blind, neuro-muscular disorders, etc.) that conventional or standard evaluative procedures cannot be employed.

(5) When the circumstances, e.g., prejudice, institutionalization, family pressures, parental interference, surrounding the immediate or the "home" situation are such that a realistic, objective appraisal of the individual's capacities and limitations cannot be conducted.

(6) When practical considerations suggest liberal policies in utilization of the facility in order to insure its growth and development as a part of the overall structure for rehabilitation in the state.

While the above guidelines are believed to be applicable to any process in which the appraisal of vocational potential is a basic factor, the following guidelines are offered as more restrictive or more applicable to the individual counselor and/or client.

(1) recognition (by Counselor) of inability to make a judgment in the particular case;
(2) need to test physical capacities and tolerance of industrial type pressures;
(3) desire to give the apparently "not feasible" cases an evaluation prior to making a determination to close the case;
(4) when a client has had no work experience and needs exposure to a realistic work situation;
(5) when a tentative job or training choice has been made which the counselor or client wishes to confirm through more comprehensive evaluation or exploration; and
(6) when the Counselor questions the client's choice of job objective and believes that it should be tested in a structured situation.

ADVANTAGES TO FACILITY EVALUATION

Disregarding the premise that formal, facility evaluation offers a more economical, efficient, and exacting approach to assessment of a disabled person's vocational potential, there are certain other advantages which are of immediate and practical benefit to the Counselor.

(1) Techniques employed will be vocationally oriented and recommendations will be consistent with agency policy, objectives and philosophy.

(2) A comprehensive approach will be employed and the various representative disciplines--medical, psychological, social, vocational--will be integrated into a vocational "diagnostic" team. (See Appendices XI and XIII)

(3) The findings will be interpreted in reference to their vocational implications rather than as diagnostic or treatment entities.

(4) Where evaluation is carried out in a comprehensive facility, the transition from evaluation to "service" can be expedited.

CONTRAINDICATIONS FOR FACILITY EVALUATION

Formal, facility evaluation services, unlike the philosophical mountain-climber, should not be used simply because they are there. In many circumstances and situations the utilization of formal, facility evaluation services would not only be meaningless and inappropriate, but contraindicated.

A formal, facility evaluation may not be indicated when:

(1) the client has very recently been successfully employed and intends to return to his work as soon as physical restoration services have been rendered;
(2) the client has been successfully employed and only a minor shift is contemplated in the type of work that he will do in the future;
(3) the individual is not cooperative nor interested in participating in evaluative procedures necessary to outline a realistic and feasible plan of rehabilitation services; and
(4) the information available, or obtainable by the counselor, or through the utilization of "specialists" (physician, psychologist, psychiatrist) is adequate, in content and interpretation, to plan a suitable program of services.

DISADVANTAGES OR WEAKNESSES OF FORMAL, FACILITY EVALUATION

The supposition that facility evaluation involving the various specialties and disciplines offers a better and more thorough approach to the problem of assessment of vocational potential is likely a valid one but there are several intrinsic weaknesses or disadvantages to facility evaluation that must be considered or weighed in selecting candidates for referral.

(1) In most cases arrangements for a facility evaluation require that the client be transplanted from his "real" environment to an artificial one. Consequently, the validity of the measurement of his behavior and performance may be questionable.

(2) Facility evaluation more often than not precludes the participation and involvement of the counselor which may lessen the applicability of the results and reduce the value of recommendations made.

(3) Facility evaluation makes it impractical to involve the client's family; and the family forces and influences, either positive or negative, acting on the client and which can mean the difference between successful and unsuccessful rehabilitation, cannot be assessed.

COUNSELOR RESPONSIBILITIES IN UTILIZING FORMAL, FACILITY EVALUATION

1. Familiarize self with operation and function of evaluation units through

personal visits or correspondence. A thorough knowledge of the operation and function of the unit or facility will facilitate the proper selection of clients; will provide first-hand the information necessary to prepare the client for the evaluation services to be undertaken; and will enhance and expedite communication between the evaluation staff and counselor.

2. Preparation of the client. Once a client has been selected for formal facility evaluation the Counselor should provide a detailed explanation regarding the facility, the procedures to be employed and a frank explanation of the purpose and reason for planning the evaluation program and its meaning in terms of the over-all rehabilitation process.

3. Transmittal of all available medical, psychological, social, vocational, personal and historical information as well as Counselor opinions and judgments which have been formulated. The more information regarding the client the facility has access to, the more thorough and meaningful the evaluation process can be. Knowledge of previous tests, examinations, etc. are important in developing conclusions and may prevent unnecessary duplication and the recording of invalid findings in many instances.

4. Maintain contact with the client during the evaluation process. It is important that Counselor's interest be maintained and conveyed to the client through personal visits and/or correspondence.

5. Seek clarification or qualification of reports or recommendations, if necessary. The results of any evaluation process are only as good as the reporting. If the reports are unclear, contradictory, too technical, or ambiguous the Counselor owes it to himself and to the Evaluation staff to call their attention to the deficiencies or inadequacies of the reporting.

6. Report follow-up information to facility or evaluation unit. One of the chief ways to analyze the effectiveness of the evaluation and accuracy of predictions or recommendations is through follow-up of evaluatees. Once the evaluation is concluded, the evaluation staff's communication with the client is cut-off and they must rely on the referring counselor for follow-up information.

Finally, the decision to utilize a facility for evaluation in a particular case is a matter of professional judgment on the part of the Counselor. Center evaluation should never be substituted for individual counselor responsibility for client evaluation nor be employed as a crutch to take the place of counseling.

SECTION C

ORGANIZATION AND UTILIZATION OF COMMUNITY RESOURCES TO OBTAIN EVALUATION SERVICES

PREFACE TO SECTION C

Pending ammendments to the Vocational Rehabilitation Act may change the existing pattern that has been the approach to the development of evaluative facilities. Some of the proposed changes are so basic that they could call for the development of new administrative philosophy and policy. Certainly, procedure and interagency relationships will be revised.

These circumstances limit the conclusion that can be reached by this subcommittee at this time. It is recommended that this aspect of the whole study be given particular attention by the next Study Group. It could be that the subject area of this Section should be modified, and careful attention given to development of guidelines for implementation of ammendments as passed by Congress.

The material that follows represents an effort to set forth some basic general principles as they are now understood. Because of the wide variations among communities in their interest in and ability to develop evaluative facilities, it is difficult to be specific in suggesting community action. There is the further consideration that the development of evaluative facilities is still new enough that there are wide variations in concepts and procedures.

It is recognized that the field counselor, in determining the vocational potentials of his clients, needs a variety of diagnostic services which could be secured from sources other than comprehensive rehabilitation facilities. Such services might include special medical examinations, psychological or psychiatric evaluations, work evaluation, job-tryout, etc., which may be needed separately or collectively. The committee, therefore, recommends that further study of the above areas be made by future study groups.

ORGANIZATION AND UTILIZATION OF COMMUNITY RESOURCES FOR DETERMINING VOCATIONAL POTENTIAL OF REHABILITATION CLIENTS

The last few years have seen a growing interest in the development and use of vocational evaluation facilities. The rehabilitation agencies, both public and private, have provided much of the impetus because of their need for effective diagnostic appraisal of individuals with limitations so severe that they cannot be effectively evaluated with use of traditional resources. To meet this need, many interested community groups have initiated plans to provide these services and have been willing to appropriate considerable resources to this end. Substantial amounts of public funds have been dedicated to this movement.

Growth has been so rapid and with limited precedent that appraisal of its effectiveness has been difficult. The pace of this development will likely increase. Efforts to develop bases and principles to regulate its growth must be redoubled.

PRINCIPLES OF COMMUNITY ACTION

In some instances state rehabilitation agencies, supported primarily by public funds, have developed and operated their evaluation facilities. In some other instances, private organizations have assumed the major role. In many more instances the establishment and management has depended on cooperative community effort. Almost all require some degree of community participation to survive and function effectively.

To accomplish this organization and utilization of community resources, it seems appropriate that we turn to the research and experiences of those who have been involved for some time in social action. Sociologists have studied intensively the processes of community development. Probably the richest source of guidance and information is in the material prepared by the sociologists for the use of the Cooperative Extension Services in the various land grant colleges. One such pamphlet opens with a statement of philosophy which includes,

> ". . . because in Community Development one is dealing with group action instead of individual action, both the process and the type of information has to be different."[1]

There follows a step by step explanation of how to organize and use community committees. Another paper by George M. Beal and Daryl J. Hobbs[2] opens with the statement,

> "The success on any community or area development program depends in large part on how effectively the program mobilizes human and nonhuman resources in the action phase. If not carried through to action or completion the best plans are of little consequence; they accomplish little beyond providing a stimulating exercise for the planners. Mobilizing the resources of a community or area to achieve the objectives of development is a process of social action. Whether the project be a new golf course, an area

> vocational training school, a labor survey, a nursing home or a community education program the process of attaining the objective is social since it depends on motivating key people and organizations to participate actively in the action necessary to accomplish the development objectives."[3]

There follows a statement of the fifteen steps that are generally regarded as necessary to accomplish social action. These procedures seem readily applicable to community movements in rehabilitation. They are:

1. Analysis of the Existing Social System
2. Convergence of Interest
3. Analysis of Prior Social System
4. Delineation of Relevant Social Systems
5. Initiating Steps
6. Legitimation
7. Diffusion Sets
8. Definition of Need by More Relevant Groups and Organizations
9. Decisions (Commitment) to Action by Relevant Systems
10. Formulation of Objectives
11. Decision on Means to be Used
12. Plan of Work
13. Mobilizing Resources
14. Action Steps
15. Evaluation

Translation of some of these concepts from their sociological context to rehabilitation terminology leads to the observations made in the following paragraphs.

SURVEYING NEEDS FOR FACILITIES

Prior to undertaking preliminary steps toward organizing or developing community resources to provide evaluation services it is imperative that the need for additional resources be definitely and conclusively established. Not only should existing facilities be studied in detail, but the present and potential utilization of these facilities should be appraised.

A review team, composed of rehabilitation and cooperative and supporting agency personnel should be formed to thoroughly survey and analyze all existing public and private organizations currently in operation within the community. The information gathered through this study should be analyzed in such a way as to pinpoint the areas of rehabilitation services that are particularly strong and need no expansion and those areas that are especially weak and need strengthening. The study should reflect the type and extent of services available and should identify those that can be expanded or upgraded through modification or reorganization and thus more economically and practically satisfy the need for additional evaluative services.

ROLE OF THE STATE AGENCY

A stage agency has responsibilities in the organization and utilization of community resources for the determination of vocational potentials of its clients. After the need for a facility or a service has been established, the state agency should supplement the efforts of field counselors by furnishing expert consultation services needed in the organization and development of such facilities. In instances where the stimulation of community interest is needed, in order to secure needed evaluative services, state agencies should furnish educational material, speakers to present the material as well as other assistance to supplement the efforts of the local counselor and supervisor. It is the opinion of the committee that such support by the state agency will relieve the counselor of pressures and at the same time assure local organizations that the state agency will support facilities after they are established.

State agencies, likewise, through their staff development and in-service training programs should dissiminate information to field personnel, in such a manner that new resources will be utilized to the fullest practical extent.

In order to insure that handicapped clients be furnished maximum professional services, in all diagnostic evaluation, the state agency should establish standards of performance for workshops, evaluation centers and other evaluation facilities. If authorized to do so, they should accept the responsibility for certification or approval on a state level.

The state agency, in cooperation with individual facilities, should establish rules and procedures for the inter-relationships between the counselor and the facility (who should be referred, specific services to be provided, fee schedules, content reports, inter-agency communication, etc.).

ROLE OF THE REHABILITATION COUNSELOR

The vocational rehabilitation counselor as the local representative of the state agency, should assume a key role in the development and utilizaion of diagnostic facilities. He should assume the role of consultant and coordinator. He should, however, be reluctant in accepting membership in governing boards, in order to avoid involvement in local controversy or being placed in compromising situations. In his role as consultant and coordinator, he should be sensitive to the interests of groups who might contribute to or provide diagnostic services needed for the adequate evaluation of his clients. At the same time, he should encourage the organization and development of those facilities which are actually needed, but should discourage the establishment of those which might not be economically feasible. An example would be the formation or establishment of facilities for specific disability groups in a community when one facility might be adequate for all disability groups in the community.

Where practicable, field counselors should be able to profit from the use of advisory committees in the development of new resources. Such a procedure is especially valuable in instances where local opposition might be encountered or where a special effort is needed to overcome public inertia and a lack of interest. Mature judgment, however, should be exercised in using representatives from all groups who might be in a position to make substantial contributions (hospitals, physicians, labor unions, churches, service clubs, chambers of commerce, faternal organizations, etc.).

The Counselor should be alert to gaps which may be overlooked. Examples would be the failure to plan for auxiliary services, which if not provided, would interfere with the services of the facility (adequate housing, transportation facilities, social service, meals, emergency medical care, etc.).

The structure, economy and size of the community will largely dictate the type of facility which can be planned and organized and the same factors will, in some degree, determine the extent of utilization of the facility by the Counselor. Nevertheless, once the need has been established and a facility planned through the promotion and cooperative efforts of agency personnel the Counselor serving the area has a professional and civic obligation to extend all possible support, both as a representative of the agency and as an individual interested in community affairs. He must recognize and fulfill numerous responsibilities beyond that of availing himself of the services offered.

(1) He should make himself available to the facility to serve in a consultative or advisory capacity.

(2) He must take the iniative in acquainting and familiarizing facility personnel with agency policy and procedures which will affect the type and number of clients referred, payment procedures, required reports, etc.

(3) He should communicate information regarding legislation, operation of cooperating and supporting agencies, etc., which may have a bearing on the functions and objectives of the facility.

(4) Maintain a close and continuous cooperative working relationship with the facility to insure the quality and effectiveness of services provided and their consistency with the objectives of the rehabilitation process.

Referral procedure to be followed, guidelines for the selection of clients to be referred and Counselor responsibilities in utilizing the facility are essentially the same as those outlined in Section B, which refers to the selection of clients for formal, facility evaluation.

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[1] Suggestions for Organization and Operation of Community Development Committees, prepared and distributed by Cooperative Extension Service, Purdue University, West Lafayette, Indiana.

[2] Rural Sociologist, Department of Economics and Sociology, Iowa State University.

[3] Beal, George M. and Hobbs, Daryl J. The Process of Social Action in Community and Area Development, distributed by Cooperative Extension Service, Iowa State University, Ames, Iowa.

2OF 2

ED

019485

1.0
4.5
5.0
5.6
6.3
2.8
3.2
3.6
4.0
2.5
2.2
2.0
1.1
1.8
1.25
1.4
1.6

MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS-1963

APPENDIX I

COOPERATIVE AGREEMENT
BETWEEN THE
OKLAHOMA UNIVERSITY MEDICAL CENTER
AND THE
OKLAHOMA VOCATIONAL REHABILITATION DIVISION
OF THE
STATE BOARD FOR VOCATIONAL EDUCATION

PURPOSE

It is the joint concern of the State Vocational Rehabilitation Division of the State Board for Vocational Education and the Oklahoma University Medical Center that facilities for a Comprehensive Diagnosis, Evaluation, and Treatment Center be established. Such a center would provide medical, psychological, social, vocational, evaluative and related services essential to help disabled persons so that they will become as productive to themselves and society as they are capable of achieving. The primary purpose of such a Center should be:

(1) To develop complete diagnostic and evaluative services focused upon returning disabled persons to productive activities within their limitations;

(2) To integrate such services into the regular teaching and service program of the Medical Center thus orienting physicians, paramedical personnel and patients to the importance of vocational rehabilitation is comprehensive medical care.

DESCRIPTION OF PLAN OF OPERATION

It is proposed that the Department of Preventive Medicine and Public Health of the Oklahoma University Medical Center, in cooperation with the Division of Vocational Rehabilitation, initiate a rehabilitation program in July of 1961 with the intention of expanding this program materially in January, 1962. During the first six months, staff members would be brought together to work as a team in the intensive care of a limited number of patients, both clients of the Division of Vocational Rehabilitation and patients of the Medical Center from other sources.

This six-month period would allow members of the team to become familiar with personnel and procedures of the Center as well as to learn their roles in rehabilitation and their relationships with other members of the team.

It is planned to make rehabilitation a major emphasis of the teaching program, having an equal status with Medicine, Surgery, Psychiatry, and Pediatrics while working closely with each of these. This joint endeavor is to support and strengthen the Office of Vocational Rehabilitation Grant received by the Oklahoma University Medical Center. Staff members concerned with rehabilitation would work in the outpatient clinics, seeing all patients suggested as candidates for rehabilitation, and would be available for consultation to patients hospitalized on the wards. A staff conference each day would discuss patients and plan rehabilitation programs for them individually. Students and others concerned with the care of these patients would be in attendance at the staff conferences and patients would be drawn into the planning to assure their interest, understanding, and cooperation in their own rehabilitation.

To initiate and develop such a program representatives of each of the major professions involved in rehabilitation will coordinate, and execute the program. The representatives will include a physician, Vocational Rehabilitation Counselor, social worker, clinical psychologist, clinical nurse, secretary, and consultants as required.

THE VOCATIONAL REHABILITATION DIVISION AGREES

A. To provide a Vocational Rehabilitation Counselor who will function as a coordinator of services, help to focus the diagnostic workup and functional evaluation toward realistic vocational goals, contribute to the education of other personnel in the program, orient the staff in all phases of the Vocational Rehabilitation Program, and interpret the procedures and recommendations of the Diagnostic Unit to the Rehabilitation staff.

B. To provide also a secretary to the Counselor. Both of these people will be paid out of Extension and Improvement Funds.

C. To dedicate its Extension and Improvement Funds in an amount not to exceed $18,920 for the fiscal year 1961-62 for helping the operation of this Evaluation Unit.

D. Transfer approximately $15,400 from the Extension and Improvement Funds to the University Hospital to purchase equipment and remodel facilities for the program.

E. Pay for any auxiliary services such as X-rays, laboratory work, etc. for rehabilitation clients referred to the Diagnostic Unit, as listed in our fee schedule.

THE OKLAHOMA UNIVERSITY MEDICAL CENTER AGREES

A. To furnish suitable office space for all personnel and general activities of the Rehabilitation Unit.

B. Contribute the services of a Medical Director.

C. Contribute consultative service from the various disciplines.

D. Furnish the Vocational Rehabilitation Agency a report of the group findings on each individual referred by the Vocational Rehabilitation Agency.

E. Provide the following services when their need is indicated:

1. MEDICAL

    a. Physical Examination and Evaluation
    b. Specialty Examination and Evaluation
    c. Physical or Occupational Therapy

   - d. Physical Restoration Service
   - e. Nursing

2. PSYCHOLOGICAL SERVICES

   - a. Testing
   - b. Evaluation
   - c. Psychological Counseling

3. SOCIAL SERVICE

   - a. Case Study and Evaluation
   - b. Family and Community Adjustment
   - c. Personal Adjustment Counseling
   - d. Recreation

It is contemplated that at the end of the two years of operation of the Diagnostic and Evaluative Unit, the University of Oklahoma Medical Center will assume the major financial support for the operation of a Comprehensive Vocational Rehabilitation Diagnosis, Evaluation and Treatment Center.

APPROVED THIS THE ______________ DAY OF ______________________,1961.

______________________________	______________________________
Dean of Oklahoma University Medical Center	Director, Vocational Rehabilitation

APPENDIX II

GRANTS IN REGARD TO AVAILABLE COMPONENTS OF EVALUATION AND TEACHING SERVICES

A SURVEY OF MEDICAL SCHOOLS RECEIVING VRA TEACHING GRANTS*

Schools Responding

	Services					Teaching				
	Medical School	Vocational	Social	Psycho- logical	Local or Affiliated	Vocational	Social	Psycho- logical	Medical	Joint Conferences
1	+	+	+	+	L	+	-	-	+	+
2	+	+	+	+	L	+	-	+	+	+
3	+	+	-	+	L	+	+	-	+	+
4	-	-	-	+	L	-	-	-	+	-
5					A	+	+	+	+	+
6	+	+	+	+	L	-	-	-	+	+
7					A	-	-	-	+	+
8	+	-	+	+	L	-	-	-	+	+
9	+	+	+	+	L&A	-	-	-	+	+
10	+	+	+	+	L&A	+	-	-	+	?
11	+	+	+	+	L	-	-	-	+	+
12	+	+	-	+	L	-	-	-	+	+
13	+	+	+	+	L	-	-	-	+	+
14	+	+	+	+	L&A	-	-	-	+	+

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* This material was prepared by Aubrey D. Richardson, M. D. (Consultant to Study Group II) University of Maryland, School of Medicine, Baltimore, Maryland.

Schools Responding (continued)

	Services					Teaching				
	Medical School	Vocational	Social	Psycho logical	Local or Affiliated	Vocational	Social	Psycho-logical	Medical	Joint Conferences
15	-	-	-	-	-	-	-	-	-	-
16					A	+	-	+	+	+
17	+	?	?	+	L	-	-	-	+	?
18	+	+	+	+	L	-	+	-	+	+
19	+	+	+	+	L	-	-	-	+	+
20	?	?	+	+	L	-	-	-	+	+
21	+	+	+	+	L&A	+	+	-	+	+
22					A	-	-	-	+	+
23	+	+	+	+	L&A	+	-	-	+	+
24	+	-	-	+	L	-	-	-	?	+
25	+	+	+	+	L	-	-	-	+	+
26	+	+	+	+	L	+	-	-	+	+
27	+	+	+	+	L&A	-	-	-	+	+
28	+	+	+	+	L&A	+	+	-	+	+

Schools Not Responding

	Services					Teaching				
	Medical School	Vocational	Social	Psycho-logical	Local or Affiliated	Vocational	Social	Psycho-logical	Medical	Joint Conferences
1					A	?	?	?	+	+
2	+	+	+	+	L	-	?	-	+	+
3	+	+	+	+	L	+	?	?	+	?
4					A	-	-	-	+	+
5	+	+	+	+	L	?	?	?	+	+
6					A	?	?	?	+	+
7	+	+	+	+	L	+	+	+	+	+
8	+	?	?	+	L	-	-	-	+	?
9	+	+	+	+	L	+	+	-	+	+
10					A	?	?	+	+	?
11	+	+	+	+	L	+	+	+	+	+
12	-	-	-	+	L	?	?	?	+	-
13	+	+	+	+	L	?	?	?	+	?
14	+	+	+	+	L	?	?	?	+	?
15	+	+	+	+	L	?	?	?	+	?
16	?	+	+	+	L	?	?	?	+	?
17	-	+	+	+	L	?	?	?	+	?

Schools Not Polled

	Services					Teaching				
	Medical School	Vocational	Social	Psychological	Local or Affiliated	Vocational	Social	Psychological	Medical	Joint Conferences
1					A	+	-	+	+	+
2	-	-	-	-	-	-	-	-	-	-
3	-	-	-	-	-	-	-	-	-	-
4	+	+	+	+	L	+	-	+	+	+
5	+	+	+	+	L	+	-	-	+	+
6					A	+	+	+	+	+
7					A	-	-	-	+	+
8	+	+	+	+	L	?	?	?	+	+
9	+	+	+	+	L	?	?	?	+	+
10	+	+	+	+	L	?	?	?	+	?
11	+	+	+	+	L	?	?	?	+	?
12					L	?	?	?	+	+

APPENDIX III

DEPARTMENT OF PREVENTIVE MEDICINE AND REHABILITATION
UNIVERSITY HOSPITAL
ADULT EVALUATION CLINIC
PHYSICAL ABILITY RATING FORM

Blank Squares = No Restriction

0 = No Ability

Written Numbers = Maximum Limits of Ability in Hours during Working Hours of 8-Hour Day

NAME____

AGE HEIGHT WEIGHT

PHYSICAL FACTORS:

	1	1— 5 lbs.	Total Lifting Ability—Including Pushing and Pulling Effort	
	2	6—10 lbs.		
	3	11—25 lbs.		
	4	26—50 lbs.		
	5	51—100 lbs.		
	6	100+lbs.		
	7	1— 5 lbs.	Carrying Ability— Carrying Ability means that portion of Total Lifting Ability which may be used in Carrying	
	8	6—10 lbs.		
	9	11—25 lbs.		
	10	26—50 lbs.		
	11	51—100 lbs.		
	12	100+lbs.		
	13	Right	Fingering—Fine Dexterity	
	14	Left		
	15	Right	Handling—Including Coarse Fingering	
	16	Left		
	17	Right	Below Shoulders	Reaching
	18	Left		
	19	Right	Above Shoulders	
	20	Left		
	21	Right	Hammering or Throwing	
	22	Left		
	23	Sitting		
	24	Total Time on Feet		
	25	Standing or Moving About in Small Area		
	26	Walking		
	27	Running		
	28	Jumping		
	29	Stairs or Ramps	Climbing	
	30	Ladders or Scaffolds		
	31	Right	While Sitting	Treading—Operating Foot Pedals
	32	Left		
	33	Right	While Standing	
	34	Left		
	35	Stooping—Low-Back Bending		
	36	Crouching—Knee Bending		
	37	Kneeling		
	38	Crawling		
	39	Reclining—Working Horizontally		
	40	Twisting—Spine		
	41	Waiting Time—Periods of Inactivity on Job		

20/	42	Far-Corrected Snellen	Vision
20/	43	Near-Corrected Snellen	
	44	Color	
	45	Depth	
	46	Hearing	
	47	Speaking	
	48	____________	Other Physical Factors
	49	____________	

ENVIRONMENTAL FACTORS:

	50	Inside or Protected from Weather	
	51	Fair Weather	Outside Without Weather Protection
	52	Wet Weather	
	53	Hot	Due to Conditions Other than Weather
	54	Cold	
	55	Sudden Temperature Changes	
	56	Humid	
	57	Dry	
	58	Operating or Around Moving Vehicles or Objects	
	59	Hazardous Machinery	
	60	Sharp Tools or Materials	
	61	Cluttered Floors	
	62	Slippery Floors	
	63	High Places	
	64	Electrical Hazards	
	65	Exposure to Burns	
	66	Explosives	
	67	Radiant Energy (Kind):____________	
	68	Poor Lighting	
	69	Poor Ventilation	
	70	Toxic Conditions (Kind):____________	
	71	Wet Working Quarters	
	72	Close or Cramped Quarters	
	73	Vibration	
	74	Noise	
	75	Working With Others	
	76	Working Around Others	
	77	Working Alone	
	78	Rotating Shifts—Zero if only day shift is suitable	
	79	____________	Other Environmental Factors
	80	____________	

REMARKS:____

____

____

____

L1017 DATE____________________ PHYSICIAN____________________

APPENDIX IV

SEVERITY OF DISABILITY

Physical - Psychosocial

1. Potential disability only, if the impairment is neglected.

2. Detectable disability causing no handicap as yet.

3. Disability causing handicap in one, or potential handicap in more than one area of living, as yet requiring no significant adjustment of accustomed behavior.

4. Disability causing handicap in more than one area, not severe enough to require special adjustment except in personal habits.

5. Physical disability severe enough to require special environmental, educational, and/or vocational adjustments but no continuous supervision.

6. Psychosocial disability severe enough to require special environmental, education, and/or vocational adjustments but no continuous supervision.

7. Physical _or_ psychosocial disability severe enough to require supervision in specialized facilities for some activities: social, educational, vocational.

8. Physical _and_ psychosocial disability are involved, handicapping one or more but not all areas, as in 6.

9. Physical and psychosocial disability are involved, handicapping all areas to a marked degree, as in 6.

10. Disability severe enough to enforce complete dependence for all care in a permanently supervised environment.

APPENDIX V

ENERGY EXPENDITURE

Physical resources currently available	Physical Demands Characterized by .1 Amount; .2 Duration; .3 Intensity
0 - Maximal	0 - .1 Unrestricted .2 16 hours of activity 8 hours applies 8 home/recreation .3 Sustained pace at will
1	1 - .1 Unrestricted .2 16 hours 8 applies 8 home/recreation .3 Variable pace at will
2	2 - .1 Unrestricted .2 16 hours 8 applied 8 home/recreation .3 Variable pace, occasional speed-up
3	3 - .1 Selected upgrading .2 16 hours 8 applied 8 home/recreation .3 Sustained moderate pace
4	4 - .1 Selected therapeutic .2 16 hours 8 applied 4 recreation 4 rest .3 Sustained at own best pace
5	5 - .1 Modified for impairment .2 12--16 hours 8 applied 1-4 recreation 4-7 rest .3 Variable: below/up to own best pace

6		6 - .1 Adjusted: regular restbreaks .2 8-16 hours 2-8 applied 6-9 recreation 8-0 rest .3 Intermittent: slow/to own best pace
7		7 - .1 Prescribed gradation .2 4-16 hours __________ prescribed __________ prescribed __________ prescribed .3 __________ prescribed
8		8 - .1 Restricted .2 1-4 hours 1-4 applied 3-0 home/recreation .3 Minimal pace
9		9 - .1 Grossly restricted .2 As able .3 Minimal pace

APPENDIX VI

THE MEDICAL ASPECTS OF AN INSTRUMENT DESIGNED TO EVALUATE REHABILITATION FACILITIES

Client Study

Physical

- Dates and treatment given.
- Treatment by other physicians.
- Names and addresses of hospitals or clinics where treated.
- Dates and treatment given.
- Hospital or clinic number if known.
- General physical condition, general health.
- Physical appearance.
- Capacity to stand, walk, lift, etc.
- School health record.
- Secondary disabilities.

Admission Staff

Are the components of the client study, including medical information, discussed using a multidiscipline approach?

Is the medical information brought to the panel, factual and adequate for discussion?

Evaluation

Does the evaluator give sufficient attention to the pre-entrance case study?

Medical

- General physical examination.
- Specialty examination.
- Treatment.
- Therapy.
- Prosthesis.
- Prognosis.

Are environmental factors which affect client's adjustment to work identified?

Environmental Factors

- Light
- Heat
- Cold
- Noise
- Sudden temperature changes
- Wet
- Humid
- Inside
- Outside
- Fumes

Frequent adaptation to darkness or brightness
Odors
Confusion
Isolation
Vibration
Dust
Toxic conditions
Poor ventilation
Safety hazards

Are physical factors which affect client's functioning on job identified?

Physical Factors

Lifting
Carrying
Pushing
Pulling
Climbing
Balancing
Stooping
Kneeling
Crouching
Crawling
Reaching
Handling
Fingering
Feeling
Teaching
Hearing
Seeing
Physical stamina
Endurance
Manipulative skills
Light work
Medium work
Heavy work
Coordination
Locomotor ability
Standing

Training

Does the training program take into consideration the findings of the pre-entrance case study?

Is the training designed to develop capacities to perform?

Does the training program provide work conditioning?

Does the training program develop physical coordination and motor control?

Are clients instructed in ways of making the best use of their physical self?

Are clients instructed in ways of increasing their physical strength?

Are clients instructed in ways for compensating for physical handicap?

APPENDIX VII

Analysis of staffing patterns of 387 Rehabilitation Facilities in the Contental United States as reported in the Directory of Rehabilitation Facilities by The Association of Rehabilitation Centers.

Full-time equivalents for the following:

Physician + Psychologist + Social Worker + Vocational Counselor -- 87

University, Medical Center or Hospital Based ---	35
Rehabilitation Center, Hospital or Other -------	52
	87

Average full-time equivalents:

	Vocational Counselor	Psychologist	Social Worker	Doctor
University, Medical Center or Hospital	1.48	.92	2.74	2.84
Rehabilitation Centers, Hospitals, Institutes and Others	1.09	1.20	1.96	4.41

Full-time equivalents for Vocational Counselors ------------ 145

Vocational Counselor + Physical Restoration + Psychological Services --- 132

No full-time equivalent Physician ---------------- 7

No full-time equivalent Social Worker --------- 2
No full-time equivalent Psychologist ---------- 2
No full-time equivalent of either ------------- 1

No full-time equivalent Social Worker ------------ 27
No full-time equivalent Psychologist ------------- 15

No full-time equivalent of either ----------- 11

APPENDIX VIII

PSYCHOLOGICAL SERVICES*

A. GENERAL CONSIDERATIONS---It is the policy of the Oklahoma Division of Vocational Rehabilitation to provide psychological services as an integral part of the rehabilitation process. Psychological services are provided by rehabilitation counselors, staff psychologists, and in some instances, may be secured from psychologists outside the agency. Generally speaking, the need for psychological evaluations arises under the following circumstances:

1. When Conventional Testing is Indicated.

In counseling with clients whose psychological equipment (mental capacities, aptitudes, dexterities, interests and personality traits) has had an opportunity to develop normally. It includes those individuals whose disabilities or environment have not adversely affected their ability to take tests. For example, orthopedic impairments of not more than three extremities, most cardiovascular conditions, most forms of tuberculosis, minor hearing losses, diseases of the respiratory system, skin conditions, cosmetic defects and diseases of the genito-urinary system. This group of clients can usually be adequately tested by using general intelligence tests, special aptitude tests, achievement tests and personality or interest inventories. (This type of testing represents level B, as recommended by the American Psychological Association.)

In most instances, the rehabilitation counselor, by virtue of his academic training and professional experience, is competent to administer, and evaluate psychological tests on this level and the agency expects him to do so.

2. When Clinical Testing is Indicated.

In counseling with clients having language handicaps, emotional or nervous conditions, mental retardation, serious visual or hearing impairments, cerebral palsy, orthopedic impairment of both upper extremities and in some instances, homebound or bedridden individuals who have been incapacitated for long periods of time. Tests used for testing individuals listed under paragraph 1 above, as a general rule, are not adequate to evaluate this group of clients. Such individuals require clinical tests of intelligence, personality tests and projective methods. In most instances, rehabilitation counselors do not have the training and experience required for this type of testing. Those who are competent to do so, do not have the time to do it while they are serving a general caseload. The caseload counselor is, therefore, requested to refer clients in this group to a staff psychologist or an outside psychologist except in unusual circumstances.

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* This material is an excerpt from the Oklahoma Rehabilitation Services Casework Manual. The material has been adapted from the publication "Psychological Services in Vocational Rehabilitation" by Salvatore G. DiMichael and from other sources to serve as a guide for providing psychological services by the Oklahoma Agency.

3. Additional Instances Where Clinical Testing may be Indicated.

In those instances where, during the counseling process, it becomes evident that psychological tests listed under paragraph 1 above are not adequate to evaluate the individual. Such individuals should immediately be referred for the type of clinical testing and evaluation described under paragraph 2 above. This will include those clients whose behavior indicates the need for psychiatric consultation. (Referral will usually be made for a psychological evaluation before referral for a psychiatric evaluation is considered, however, circumstances may warrant direct referral to a paychiatrist.)

4. Mental Retardation.

In those cases where mental retardation or mental deficiency is the only known disability, it is necessary to have a functional I. Q. score based on a clinical test of intelligence described under (2) above in order to determine basic eligibility for vocational rehabilitation services. For reasons previously mentioned, the caseload counselor will usually refer this type of client to the staff psychologist or an outside psychologist for a psychological evaluation.

B. AGENCY STANDARDS FOR PSYCHOLOGICAL SERVICES -- Clinical tests of intelligence, personality tests and projective methods require a substantial understanding of testing and supporting psychological principles with supervised experience in the use of these devices. The Agency, therefore, takes the position that such tests only be used by:

1. Members of the American Psychological Association, who are Diplomates of the American Board of Examiners in Professional Psychology or Fellows in appropriate divisions; and/or

2. Members of the A.P.A. with at least a Master's Degree is Psychology who have had at least one year of supervised experience under a person with qualifications listed under 1 above; and/or

3. Individuals with a Doctor's Degree (Ph.D. or Ed.D.) with major empahsis on clinical psychology from a recognized college or university, who are teaching psychology in a college or university setting, and/or

4. Graduate students who are enrolled in courses requiring the use of such devices under the supervision of a qualified psychologist, and/or

5. Members of kindred professions who can show that they have had adequate training in clinical testing including both theory and practice in the administration, scoring, and interpretation comparable to that specified above.[1]

C. PSYCHOLOGICAL INFORMATION NEEDED BY COUNSELOR - When a rehabilitation counselor refers a client to a psychologist, he is seeking information which will enable him to make one or more of the following decisions or determinations:

1. Is the client eligible? (Does his impairment impose sufficient limitations to cause a vocational handicap or is his impairment too severe.)

2. To help the client understand himself, identify his problems, understand his weaknesses and strengths and to assist him in making reasonable vocational plans.

3. Make a determination as to whether a rehabilitation plan can be formulated, which is in accordance with Agency policies and regulations and which will have a reasonable chance of getting the client into remunerative employment.

It is, therefore, evident that the report of a psychological evaluation, to be of value to a rehabilitation counselor, must differ in content and emphasis from those done for other social agencies. As a suggestion for assisting psychologists in making reports which will be of maximum value for the rehabilitation counselor, the following points should be covered:

1. A functional I.Q. based on an individual clinical test such as the Wechsler, WAIS or WISC. (This information is always needed when mental retardation or deficiency is the major disability, in order to determine eligibility.)

2. Personality dynamics are interesting and valuable in all phases of counseling, but the rehabilitation counselor is primarily interested in the following points. The psychologist should, therefore, cover the following in his assessment when applicable:
    (a) Extent of neurosis or psychosis, if any, and whether or not psychotherapy or psychiatric evaluation is indicated;
    (b) Presence of personality or character traits which may impede or preclude successful rehabilitation attempts;
    (c) In the case of a pre-psychotic or a post-psychotic, whether or not the disease is in sufficient remission to enable the client to withstand the pressures of a rehabilitation program;
    (d) In the case of an emotionally disturbed person, whether or not there is sufficient stability to enter and to continue in a rehabilitation program; including identification of specific restrictions or limitations where the response is a qualified affirmative;
    (e) In the case of addiction to drugs or alcohol, whether or not there is sufficient ego strength to warrant a favorable prognosis for vocational rehabilitation;

(f) An assessment of the clients motivation;

(g) Although it is the counselor's responsibility to approve specific job objectives, an opinion regarding the level of occupations which might be appropriate from the standpoint of the client's native ability and personality structure, would be helpful; and

(h) What is the over-all prognosis for eventual rehabilitation with regard to psychological factors?

D. REFERRING THE CLIENT FOR A PSYCHOLOGICAL EVALUATION -- When a counselor has decided to refer a client for a psychological evaluation, certain very important steps are necessary. The client should be adequately prepared for the evaluation by being fully informed why he is being referred. The psychologist, likewise, must be given pertinent information concerning the client. Such information might be summarized as follows:

1. Prepare the client for the referral by securing his permission and by explaining in a professional manner why he is being referred. Prepare him in a manner similar to the way you would prepare him for a referral to any other specialist. Do not say, "We are going to send you for some tests." Explain, for example, that you need more information about his strengths and weaknesses, how he thinks, and how he reacts to certain situations in order to be of more help to him in planning a rehabilitation program.

2. Provide the psychologist with personal data such as name, age, sex, marital status, educational level, and work experience. Relevant social history should also be included if it is available. If some test results are already available, give them to the psychologist.

3. State clearly why you are making the referral. What problems the case presents to you and what you would like to find out. A good referral with specific questions and information will enable the psychologist to give you a more meaningful report.

4. Do not ask the psychologist to determine eligibility or to select the job objective. These decisions are the responsibility of the counselor. It is, however, helpful to let the psychologist know about tentative plans if any have been formulated. The psychologist's job is to identify emotional maladjustments, assess personality traits, to determine current intellectual functioning and to point out strengths and weaknesses which will assist the counselor in determining eligibility and in planning with the client for an appropriate rehabilitation plan.

E. REFERRAL FOR PSYCHIATRIC CONSULTATION

1. In most instances, a client should be seen by a psychologist before a referral is made for a psychiatric evaluation. An exception would be when the client's observed behavior or current history is so bizarre that vocational rehabilitation is questionable or when he

exhibits psychotic behavior to the extent that a psychiatric opinion is needed before further action is taken on the case.

2. In referring a client to a psychiatrist, the same information should be furnished as that given to the psychologist. In all instances, a copy of the psychological report should be furnished, if one is available. It is very important that the client's permission be secured and that he be properly prepared for the referral.

3. The most satisfactory method for referring a client to a psychiatrist is to send the psychiatrist a letter giving the pertinent information, reasons for referral and explaining what you need to know from a psychiatric standpoint.

F. WHEN ARE PSYCHOLOGICAL SERVICES NEEDED?

1. When long term or expensive training is involved.
    - (a) When the job objective involves college training. (An academic aptitude test such as the Ohio State Psychological Examination should always be given unless reliable results of similar tests are available.)
    - (b) When the job-objective involves more than three months training.
    - (c) When a client's work experience is not related to the field in which he is being trained.

2. Mental retardation has to be determined.
    - (a) When the applicant's eligibility for rehabilitation services is based on mental retardation as the primary disability, or
    - (b) Mental retardation is suspected as a secondary disability.

3. When client or counselor needs information or confirmation of client's abilities, aptitudes, achievements, interests and personality traits.
    - (a) Counselor or client undecided.
    - (b) Confirmation of a tentative job objective choice.
    - (c) The job choice of the client is considered unsuitable by the counselor.

4. When data on the client's capacities are lacking or contradictory.
    - (a) No work or educational record available.
    - (b) Case history shows contradiction between client's abilities and stated interests.

5. Important talents, abilities, disabilities or deficiencies are suspected.
    - (a) A special talent is suspected but no reliable evidence is available.

(b) A specific deficiency is reading, mathematics, or English is suspected which will affect choice of objective.

6. A person is known or suspected of having disabilities which require specialized evaluations.

(a) Brain damage, head injuries, cerebral palsy, epilepsy or other neuro-muscular disorders.
(b) Emotional disturbances or where it is desirable to determine the need for psychiatric consultation.
(c) Disabilities which require specialized individual testing such as the mentally retarded, the blind, the totally or seriously hard of hearing, aphasics, those with severe reading deficiencies, problem cases, an individuals whose employment record indicates that they are "accident prone".

G. THE USE OF PSYCHOLOGICAL EVALUATIONS FOR DETERMINING ELIGIBILITY

1. The Emotionally Disturbed

Tests designed to evaluate special disability groups including the emotionally disturbed (individual intelligence tests and all techniques designed to evaluate basic personality functioning) require more training and experience than is usually possessed by the caseload counselor.

In cases where an emotional disturbance (the psychosis, psychoneuroses, personality disorders and character or behavior disorders) is the major disability, the condition must be identified (diagnosed) by an approved psychologist or psychiatrist. Parenthetically, it should be added that any client whose major disability or disabilities fall within some other category, should be referred for a psychological evaluation if he exhibits significant deficits in personal or social adjustment which might adversely affect his rehabilitation program. In most instances, the counselor will secure a psychological evaluation before he refers a client for a psychiatric evaluation unless there are cogent reasons for a direct referral.

The purpose for referring clients for a clinical evaluation is usually two fold: (1) To secure information for determining whether client's condition causes limitations which result in a vocational handicap and (2) To get a professional opinion as to whether these limitations are so severe that vocational rehabilitation services are not indicated. The counselor must exercise mature discriminating judgment in using the information secured from psychological evaluations. Practically all emotional conditions exist to a degree in most human beings. The mere fact that a psychologist or a psychiatrist diagnosis an emotional condition which imposes limitations is not enough to justify eligibility. The limitations must be of such a nature that they cause a substantial vocational handicap. On the other hand, the limitations must not be so severe that vocational rehabilitation is impossible with the resources available to the counselor. If the counselor does not evaluate the other information he has secured in connection with the psychological and psychiatric information, a large segment of our entire population might be declared eligible for service when there is no legal basis for such action. On the other hand, the same discriminating judgment is necessary in accepting clients with severe emotional disturbances in order to prevent a waste of taxpayer's money, possible injury to the client or others and a waste of the counselor's time.

In instances where psychotherapy is recommended, the counselor should carefully evaluate the need for such service, the availability of facilities and other factors in the case. In addition, he should discuss the case with his area supervisor before making any arrangements for therapy.

Limitations resulting from emotional conditions are so complex and vary so much among individuals and among different types of mental illness that it is impossible to enumerate a comprehensive list of limitations. The following are examples of limitations which might be considered as evidence that a person is vocationally handicapped as a result of an emotional condition:

(a) If a person has recovered from a mental illness, there may be a deterioration of intellectual function which may cause a vocational handicap.

(b) There may be a loss of occupational proficiency as a result of disuse during the illness including the period of hospitalization.

(c) Recovery from a mental illness is uaually considered a remission and not a cure. The fact that such an illness has occurred may pre-dispose the person to a recurrence if he is exposed to excessive stress.

(d) There is frequently a lowering of the frustration tolerance (ability to function successfully in a competitive situation) of persons with mental illness due to disturbed thinking, emotional imbalance, or behavioral anomalies associated with the illness.

(e) Although not a determining factor by itself, the counselor should always remember that commitment to a mental institution sometimes attaches a stigma which can cause a distinct vocational handicap.

2. Mentally Retarded

The providing of vocational rehabilitation services to the mentally retarded group is based on the viewpoint that they as a group, are essentially normal people whose mental functioning places them at the lower end of a normal distribution of intellectual competence. In order to conform to the legal requirements of the laws under which we operate and to fulfill our responsibilities to the client and to the taxpayer who pays the bill, we must assume that they will grow up, although at a slower rate and eventually be able to engage in remunerative employment if they receive specialized and skilled assistance. The causes, types and degrees of mental retardation are so varied and so complex that careful judgment must be exercised in each case. Each individual, however, must meet the following criteria in order to be declared eligible for vocational rehabilitation service.

(a) The individual must be of working age (16) or will be, upon completion of his rehabilitation plan (preparation for employment.)

(b) It has been demonstrated by acceptable psychological or psychiatric evaluation that a mental impairment exists which makes it unlikely that he will be able to adjust to competitive employment without specialized assistance. The evaluation must always include an individual intelligence test such as the Wechsler-Bellevue or the Stanford Binet, administered by an approved examiner, and which shows an I. Q. score within the range from 50 to 78, subject to the following exceptions:

1. Some cases with a measured I. Q. score above 78 may, in rare instances, be eligible if the counselor is able to show that other factors such as emotional maladjustment, social immaturity, etc. are preventing the client from functioning above a mentally retarded level. Such evidence might include inability to progress beyond the sixth grade in school, emotional instability, inability to learn to read, and immature social behavior.

2. In rare instances, individuals with a measured I. Q. below 50 may be feasible for vocational rehabilitation services, if there is evidence that the person is actually functioning at a higher level than that indicated by his score on an intelligence test.

(c) The counselor, on the basis of accepted principles of vocational rehabilitation has concluded that the prognosis for eventual remunerative employment is favorable.

(d) The services he needs, to prepare for, secure or hold remunerative employment, are available through the Agency.

Thus, for an individual to be certified as eligible for vocational rehabilitation services on the basis of mental retardation, it must be demonstrated that: (1) an inadequacy of intellectual functioning has resulted from a retardation of mental growth which is manifested by a failure to perform above the level of a 9 to 11 year old child in the important aspects of education and life, (2) that this deficit in mental functioning is not so severe that his remaining mental and personality resources will prevent him from successfully completing a vocational rehabilitation program and engaging in remunerative employment.

H. STANDARDS FOR PSYCHOTHERAPEUTIC TREATMENT

Psychotherapeutic treatment for severe emotional conditions, which will respond to treatment within a reasonable length of time (3 months), may be provided in selected cases. In all instances, therapy shall be provided only by (1) psychiatrists who are certified by the American Board of Psychiatry or who have completed the required training and are "Board qualified", or who have spent a major portion of their time in a particular specialty for at least two years and are recognized as specialist in the local community (same criteria as applied to other medical specialties), or by (2) psychologist with a Ph. D. in Clinical Psychology who are regularly engaged in private practice on at least a one-half time basis or who are members of a college or university clinical psychology staff or a combination of both, or (3) individuals with at least a Master's degree in clinical psychology, who are working in a State, community, or private clinic under the supervision of a psychologist or psychiatrist who meets the requirements listed above, or (4) individuals with a Master's degree from an accredited School of Social Work, who are members of the Academy of Certified Social Workers and who have completed a minimum of five years of supervised practice in clinical settings and have a working arrangement for psychiatric consultation on private practice cases.

In all instances, the authorization for the initial three months regime of therapy must be approved by the area supervisor. Extension for an additional three (3) month period may be approved upon receipt of a written report from the therapist and upon approval by the area supervisor.

Fee: Not to exceed $15.00 per treatment hour or maximum of $30.00 per week.

I. PERSONAL ADJUSTMENT COUNSELING

Certain emotional conditions, not of such severity as to require intensive psychotherapy, may benefit from personal adjustment counseling in order to bring about a more adequate social adjustment, alleviate superficial anxiety and to facilitate more effective interpersonal relations. Such treatment may be provided in selected cases for a period not to exceed three (3) months.

Personal adjustment counseling may be provided by:

1. Clinical psychologists and psychiatrists meeding the requirements under 1 above;

2. or by Doctorates in allied professions such as speech pathology, special education, counseling and guidance. (This group should be

approved by the State Psychological Association or by their respective State professional organization.)

3. Individuals with training in clinical or counseling psychology, or speech pathology with training at the Master's degree level and who are working in State, community or private clinics under the direction of individuals who meet the requirements of 1 and 2 above.

4. Social workers with a Master's degree from an accredited School of Social Work, who are members of the Academy of Certified Social Workers and who have completed a minimum of five years of supervised practice in clinical settings.

Authorizations for extension of the original 3 month period of personal adjustment counseling may be approved upon receipt of a written report from the therapist and approval by the area supervisor.

J. LISTS OF INDIVIDUALS APPROVED FOR PSYCHOLOGICAL EVALUATIONS, PSYCHOTHERAPY AND PERSONAL ADJUSTMENT COUNSELING

Pending completion of a list of approved psychologists, and therapists, all individuals who have not been previously approved will be approved by the Chief of Rehabilitation Services before they are used on a fee basis.

APPROVED TESTS FOR USE BY REHABILITATION COUNSELORS

Each supervisor will be held responsible for seeing that an appropriate supply of tests, including manuals, booklets, answer sheets, and other material is requisitioned for each field office under his supervision. One person, in each office, should be held responsible for setting up a filing system for test materials. This person should also be charged with the responsibility of keeping a supply of tests on hand at all times to meet the needs of counselors who use them. It is imperative that the test materials be filed in a convenient location where conselors will have ready access to them.

Individual counselors should have separate files or field kits of their own which contain test materials (manuals, answer sheets, etc.) for tests most commonly used by them.

All of the following test can and in most instances should be administered by the rehabilitation counselor. The Agency does not have the funds to purchase conventional psychological testing which can be done more economically by him. In addition, there are certain advantages when the counselor is able to observe the client's behavior in a testing situation.

Mental Ability Tests

1. Otis Self-Administering Test of Mental Ability
   (a) Higher examination: Form A
   (b) Intermediate: Form A
2. Revised Beta Examination
3. Army General Classification Test
   First Civilian Edition
4. S.R.A. Tests of General Ability
   (a) S.R.A. Verbal Form
   (b) S.R.A. Non-Verbal Form
5. California Short Form Test of Mental Maturity
   (a) 1963 Short Form (Level 5 - College & Adult)
   (b) 1963 Short Form (Level 4 - Grades 9-12)

Interest Inventories

1. Occupational Interest Inventory
   1956 Revision, Lee-Thorpe
2. Kuder Preference Record
   Form CH (Vocational)

Personality Inventories

1. California test of Personality Adult (Form AA)
2. Bell Adjustment Inventory
3. Personal Audit (Form SS)

Academic Aptitude
1. Ohio State Psychological Test (Form 21)
2. American Council on Education
   Psychological Examination, College Edition

Special Ability Tests

1. The Purdue Pegboard
2. Revised Minnesota Form Board
3. Bennett's Mechanical Comprehension Test
4. Minnesota Clerical Test
5. Survey of Space Relations Ability - Form A
6. Engineering and Physical Science Aptitude Test
7. O'Rouke Mechanical Aptitude Test
8. O'Connor Tweezer Dexterity Test
   O'Connor Finger Dexterity Test
9. Macquarry Test for Mechanical Ability
10. S.R.A. Test of Mechanical Aptitude, Form AH
11. S.R.A. Clerical Aptitude, Form AH
12. Psychological Corporation General Clerical Test
13. Graves Art Design Test
14. Meir Art Judgment Test
15. Stanquist Mechanical Aptitude Test

Achievement Tests

1. Iowa High School Content Examination
2. Woody-McCall Test of Arithmetic Fundamentals
3. Wide Range Achievement Test

Miscellaneous

1. G.A.T.B.: To be secured by referring client to O.S.E.S.
2. The following tests may be given in certain situations by th rehabilitation counselor if he has had adequate training and experience. Individual counselors, however, should secure approval from Central Office through their area supervisors before using them.

    (a) Wechsler-Bellevue Intelligence Scale (WAIS) (16 to Adult)
    (b) Wechsler-Bellevue Intelligence Scale (WISC) (Ages 5 to 15)
    (c) Minnesota Multiphasic Personality Inventory

The above list contains only tests which have been used by the Agency or which are especially suitable for the vocational rehabilitation counselor's use from the standpoint of standardization, economy and ease of administration. The list is not all inclusive. If, at any time, counselors desire to use other tests which are not listed, they should contact their area supervisor.

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[1] U. S. Department of Health, Education and Welfare. Office of Vocational Rehabilitation, "Psychological Services in Vocational Rehabilitation". (Salvatore Di Michael) p. 11.

APPENDIX IX

ADEQUACY OF REHABILITATION EVALUATION

CHECK LIST FOR COUNSELORS AND SUPERVISORS

MEDICAL

1. Was existing medical information obtained? ____________________

2. Is medical information recent (not more than 90 days old)? __________

3. Is general medical information complete? ____________________

    a. Is diagnosis shown? __________
    b. Are physical and mental limitation shown? __________
    c. Is prognosis shown? __________
    d. Are recommendations shown? __________

4. Were specialty examinations recommended? __________

5. Were all recommended specialty examinations obtained? __________

6. Were specialty examinations complete (diagnosis, prognosis, recommendations, etc.)? __________

7. Were specialists board-certified or otherwise qualified? __________

8. Is additional medical information indicated? ____________________

    a. Rehabilitation Facility Evaluation? __________
    b. Speech and Hearing Center? __________
    c. Amputee Clinic? __________
    d. Other? __________

PSYCHOLOGICAL

1. Was a psychological test (or evaluation) obtained? __________

2. Is it indicated in this case (according to State Casework Manual or VRA Bulletin on "Psychological Services")? __________

3. Is sufficient information recorded to make an adequate appraisal of mental ability, aptitudes, interests, personality, motivation, etc.?

SOCIAL

1. Does counselor describe:

   a. Home conditions? ____________________
   b. Personal data? ____________________
   c. Economic factors (including Economic Need Sheet)? ____________________
   d. Attitudes of client and family? ____________________
   e. Sources of information? ____________________

EDUCATIONAL

1. Was school transcript obtained? ____________________
2. Is school transcript indicated (according to policies set forth in State Casework Manual)? ____________________
3. Is sufficient information recorded to determine?

   a. Grades completed? ____________________
   b. Preferred subjects? ____________________
   c. Educational plans or ambitions? ____________________
   d. Other revelant data? ____________________

VOCATIONAL

1. Is work history recorded? ____________________

   a. Types of jobs? ____________________
   b. Wages? ____________________
   c. Job tenure? ____________________
   d. Reason for leaving? ____________________

2. Is sufficient information recorded to determine work habits, skills, level or aspiration, attitudes, opinions of former employers, etc.?

3. Is a work evaluation needed? ____________________

4. Does client need personal adjustment training? ____________________

TOTAL EVALUATION

1. Were all data obtained in the case study analyzed or evaluated so that proper conclusions could be drawn? ____________________

2. Was the vocational plan based on the total evaluation? ____________________

APPENDIX X

ADEQUACY OF REHABILITATION EVALUATION

CHECK LIST FOR V. R. AGENCIES

A. Organization and Administration

1. Does the State Agency (Director and Supervisory Staff) consider evaluation an important part of the rehabilitation process? ______

2. Are Consultants available when needed?

    a. State Medical Consultants? ________________
    b. Local Medical Consultants? ________________
    c. Psychologist? ________________
    d. Other special consultants? ________________

3. Are methods and standards for evaluation adequately covered in the State Case ork Manual? For example, are there established guidelines for cases which require psychological evaluations? ____________

4. Are there written Guidelines for evaluation of disabilities such as aphasia, arthritis, diabetes -- or other disabilities which present certain problems? ____________

5. Are case records reviewed periodically to determine adequacy of evaluation? ________________

6. Does the State Casework Manual specify that case study data must be summarized, analyzed, and evaluated, so that proper conclusions may be drawn? ________________

B. Facilities

1. Comprehansive rehabilitation centers:

    a. Number ________________
    b. Location (s) ________________________________
    ____
    ____
    c. Are evaluation services adequate? ________________

2. Sheltered workshops:

    a. Number ________________
    b. Location(s) ________________________________
    ____
    ____
    c. Are evaluation services adequate? ________________

3. Speech and hearing centers:

    a. Number ____________________
    b. Location(s) ____
    ____
    ____
    c. Are evaluation services adequate? __________________________

4. Amputee clinics:

    a. Number ____________________
    b. Location(s) ____
    ____
    ____
    c. Are evaluation services adequate? __________________________

5. Cardiac work evaluation units:

    a. Number ____________________
    b. Location(s) ____
    ____
    ____
    c. Are evaluation services adequate? __________________________

6. Optical Aids Clinics:

    a. Number ____________________
    b. Location(s) ____
    ____
    ____
    c. Are evaluation services adequate? __________________________

7. Half-way houses:

    a. Number ____________________
    b. Location(s) ____
    ____
    ____
    c. Are evaluation services adequate? __________________________

8. Other evaluation or adjustment training facilities:

    a. Number ____________________
    b. Location(s) ____
    ____
    ____
    c. Are evaluation services adequate? __________________________

9. Do all counselors use facilities when special evaluation services are needed? ______________________

APPENDIX XI

OPERATIONAL MANUAL

HOT SPRINGS REHABILITATION CENTER
EVALUATION UNIT

Objective

The primary objective of the HSRC Evaluation Unit is to provide medical, social, psychological, and vocational information regarding a specific individual to the referral source, who may use the information as a basis for provision of rehabilitation services. To put the objective in shorter, simpler form, it is to make a valid prediction of a given client's rehabilitation potential. In order to make this prediction, it is necessary to consider or evaluate the client in four areas - medical, social, psychological, and vocational.

Method or Approach

To make a rehabilitation prediction, the Evaluation Unit employs a team approach with each member of the team functioning in a particular role. We consider the usual team to be the Doctor, the Couselor, the Psychologist, the Vocational Evaluator, and the Coordinator of Evaluation Services. Often other staff members are added to the team; the Physical Therapist, Occupational Therapist, Speech Tehrapist, Instructor, Recreation Director, and Housemother. All recommendations are group recommendations after careful consideration by each team member.

Type of Evaluation

1-day The one-day Evaluation program is designed to provide specific psychological or medical information and in most cases will consist of a limited psychological or medical examination directed toward providing specific information relative to a previously established tentative vocational objective. The one-day Evaluation was designed to serve field counselors who do not have ready access to the professional services necessary to formulate a vocational diagnosis.

10-day Evaluation A ten-day Evaluation may be designated when the field counselor wishes a person evaluated for a specific type training or when the person's physical or mental limitations are so pronounced that it is apparent only limited testing can be undertaken.

The ten-day Evaluation includes the same procedures as the 30-day, and the only difference being limited job-sample testing.

30-day Evaluation Thirty days will be the usual length of time designated for a comprehensive vocational appraisal. Generally speaking, medical and psychological diagnosis will be made during the first ten days. Vocational diagnosis based upon job-sample testing will ordinarily not be complete until the end of the thirty-day period.

PROCEDURES

Referral and Scheduling

Referral for Evaluation services ordinarily comes from a Vocational Rehabilitation Field Counselor via the Admissions Committee - Medical Director, Supervisor of Student Services, Supervisor of Vocational Training, Coordinator of Evaluation, Center Administrator, ex officio. Acceptance or rejection of student cases submitted for Evaluation is the responsibility of the Admissions Committee, of which the Coordinator of Evaluation Services is a member.

On occasion when a student is not functioning satisfactorily in a training area, he may be referred for Evaluation by his Center counselor.

Pre-Admission scheduling

All students accepted for Evaluation services are scheduled for admission by the Coordinator of Evaluation with the approval of the other Admission Committee members. Scheduled admissions are ordinarily on a "first come, first served" basis, but in special situations, priority may be exercised.

Amission to Center

The student scheduled for Evaluation follows throughout his first few hours at the Center the schedule of all new students: Tour of main building, Assignment of room, introduction to his Center counselor, and often other staff members.

Orientation

At 4:00 p.m. on Monday (admission day) a brief orientation to Evaluation services is conducted by Coordinator of Evaluation, Psychologist, and Chief Vocational Evaluator. The orientation session is not only for the purpose of getting acquainted, but also to provide an explanation of the purpose of Evaluation and some interpretation of procedures generally employed during the Evaluation period.

Social Information

Some background information accompanies each student to the Center, but we have found it necessary to obtain substantially more social and personal history. This is accomplished by means of a personal history sheet and autobiographical sketch, completed by the student as a first step in his Evaluation program. Often a personal interview will be necessary to obtain adequate background information. (The socio-economic and cultural patterns of the family may be the key to performance in certain areas. Interpersonal relationship within the family, the client's past reaction to stressful situations may well predict reaction to supervision, authority, and pressure in a training or employment situation.)

Medical

Each student who enters the Center is seen on Wednesday of the first week for medical evaluation. After initial medical evaluation, he may be referred for further examination to a specialist in orthopedics, opthalmology, or urology (at regular weekly clinic). Limitations of function are pointed out in written reports by the examining physicians. Corrective or remedial treatment may be prescribed. On occasion, medical evaluation may be extended to physical therapist (muscle testing), occupational therapist (evaluation of upper extremity dexterity and coordination and activities of daily living), and speech therapist (speech and hearing evaluation).

The medical director serves as an active and contributing member of the Evaluation team and when indicated the physical therapist, occupational therapist, and speech therapist become team members.

Psychological

Each student who enters the Center for Evaluation is seen early during the Evaluation by the Unit Psychologist who administers a battery of psychological tests designed to reveal the student's intellectual level, special aptitudes, vocational interests, and personality traits. Through the medium of clinical interviews and observation of the student's behavior, the psychologist gathers information about the student's education, experience, cultural and family background, work habits, and interpersonal relations which may have a bearing upon his training, work and emotional adjustment. The clinical information, test results, and observations are incorporated into a written report which is presented at the Evaluation Conference.

Job-Sample Testing

Job-Sample Testing is used not only as an objective method for measuring a student's aptitude or capacity for a particular type of work, but as a clinical-vocational laboratory. It permits the assesment of an individual's motivation, vocational interest, interpersonal relations, work habits, attitudes, learning, and comprehension. Testing of this nature reflects the practical aspects of the demands placed on a worker and therefore reveals what his performance and response might be in a realistic work situation. Job-sample testing, insofar as possible, is closely related to the demands of the Center training areas, but are not confined to these areas.

The number and types of tests a student may take will depend on interest, intellectual ability, aptitude, working speed, and physical limitation. Job-sample testing currently consists of TOWER tests with adaptations:

- Clerical (all)
- Drafting (all)
- Drawing (all)
- Electronics (1,2,3, & 4)
- Jewelry (all)
- Lettering (all)
- Receptionist (5)
- Leathergoods (all)

Other tests which have been developed are:

- Woodworking
- Mechanics
- Body and Fender
- Upholstery
- Furniture Refinishing
- Electrical Appliance Repair
- Office Machine Repair
- Machinist
- Painting
- Watchmaking
- Photo Offset Printing
- Sewing and Tailoring
- Machine Operation
- P.B.X. Operation

Situational tests are often utilized to provide vocational information that cannot be measured by means of job-sample testing. Situations frequently used are: elevator operation, custodial, maintenance, and food service areas. In such cases the student is assigned to the appropriate department and performs work assignments under the supervision of an experienced worker in that field. Close contact is maintained by the Evaluation Unit with the initial direction and supervision coming from this area. Work situations which are not standard test areas are often created and conducted in the job-sample area as the needs arise. (Examples: Messenger, performance of routine custodial tasks.)

A student's ability to produce is measured both from a qualitative and quantitative standpoint. Results of testing in the TOWER series are compared to establish criteria. Ratings on the non-standarized tests are made on the basis of the experience of and information obtained by the evaluator. The ratings obtained on the various tests are recorded by checking the appropriate rating on the reporting form. A five-point rating system is utilized, varying from Superior to Inferior. The ratings reflect the student's ability to perform and meet the demands of vocational training and employment situations.

A definition of the rating terms are as follows:

Superior: A positive asset. A practical certainty of successful completion of training and subsequent employment in that field of work.

Above Average: An asset. Means a high probability of successful completion of training and subsequent employment in that field of work.

Average: Means a 50/50 chance of successful completion of training and subsequent employment in that field of work.

Below Average: Means a low probability of successful completion of training and subsequent employment in that field of work.

Inferior: Means almost no possibility of successful completion of training and subsequent employment in that field of work.

Tryouts

In many cases an actual tryout in a specific training area may be provided as an auxiliary testing situation. In such instances, a written request asking for pertinent information as to the likelihood of an evaluatee being able to perform, learn, or adjust to the specific activities of the particular training or work situation is made.

Report forms of tryouts are provided to the instructor or supervisor by the Evaluation Unit. They are completed by the instructor at the conclusion of the tryout period and returned in duplicate to the Evaluation Unit.

Progress Conference

Progress conferences are held on a weekly basis. In attendancd are all professional members of the Evaluation Unit staff (coordinator, psychologists, vocational evaluators, medical director, and counselors.) The initial progress conference is held nine days after the student enters the Center. Physical limitations and any prescribed treatment which may affect the student's program are discussed. Psychological data, both of objective (test results) and subjective (clinical impression) nature, is presented. Initial results of job-sample testing are discussed and the group usually recommends direction for further job-sample testing. Any social problems which have come to the counselor's attention may be reported at this time.

In subsequent progress conferences held each week, any phase of the student's total evaluation program may be brought up for discussion. If there are no problem areas, usually a very brief report on continuance of job-sample testing by vocational evaluator to whom student is assigned will be given.

Summary Conference

The final step in any ten or thirty-day Evaluation is the presentation of reports to the Evaluation Committee for review and discussion. The Committee is composed of administrative and supervisory personnel and all staff members who have directly participated in any particular Evaluation program and acts as a recommending body, outlining a plan of services for the individual student.

The Evaluation Committee meets weekly and is chaired by the Coordinator of Evaluation Services. Participants are given prior notice of the cases to be presented for discussion through an Evaluation Summary Sheet prepared by the Coordinator of Evaluation and which contains pertinent identifying data and major points of discussion in reference to each individual case.

UNIT PERSONNEL

Coordinator of Evaluation

The coordinator assumes responsibility for the maintenance of an effective Evaluation program. It is his duty: (1) To coordinate activities of all

Center staff who are involved in Evaluation. (2) To initiate and to chair Evaluation Case Conference; to invite appropriate personnel to participate in this Conference. (3) To be responsible for the preparation of Evaluation reports and summaries which result from Case Conference. (4) To serve as a member of the Admissions Committee and as such to schedule students for Evaluation programs. (5) To be responsible for equipment and supplies within his area and to recommend purchase of any needed equipment or supplies. (6) To make recommendations to the Supervisor of Student Services for the employment of persons within the Evaluation Section. (7) To report on monthly and annual basis to supervisor of Student Services the activities of the Unit.

Psychologist

The psychologist is responsible for assessment of the student's intellectual abilities, special aptitudes, and personality and behavior factors, which might affect his rehabilitation program. It is his duty: (1) To administer and interpret standarized psychological tests and measurements for designated students. (2) To initiate clinical interviews for further assessment of the designated students. (3) To report his finds at Evaluation Conference. (4) To prepare a written report including a psychometric data sheet and clinical impression, which is ultimately sent to the referral source.

Vocational Evaluators

The vocational evaluator is responsible for the administration of job-sample tests, TOWER, and non-standardized tests to determine a student's functioning ability in a simulated work situation. It is his duty to: (1) Administer and rate performance in job-sample tests. (2) Complete forms and write necessary reports relative to job-sample testing. (3) Participate in Evaluation Conference by presenting his report. (4) Maintain an industrial and productive atmosphere in the workshop areas. (5) Effect and maintain a safety program in the workshop area. (6) Assist in the development of techniques, procedures, and practices to facilitate and improve the Evaluation program, including development of new job-sample tests.

Secretaries

Three secretaries share the clerical, secretarial, and stenographic duties in the Evaluation Unit. The secretaries are directly responsible to the Coordinator of Evaluation Services. The senior secretary assumes responsibility for general office management. It is her duty to: (1) Perform clerical, secretarial, and stenographic duties as may be assigned. (2) Assist in scheduling and coordinating the activities of Evaluation students. (3) Assist in compilation of statistical information as directed. (4) Maintain records and inventories of office supplies and equipment. The junior secretary will: (1) Assist in grading and/or scoring of non-restricted, objective paper and pencil tests. (2) Maintain records and inventories of psychological test materials. (3) Perform such clerical secretarial and stenographic duties as may be assigned by the Coordinator.

Medical Director

The medical director serves as a contributing member of the Evaluation team, through his participation in Evaluation progress and termination conferences he reports physical factors and denotes physical limitations; if indicated, plans physical restoration programs to run concurrently with Evaluation, and makes recommendation for continuing physical restoration programs at the conclusion of the Evaluation period.

Physical Therapist

The physical therapist, in addition to performing various muscle tests, may carry out a physical therapy program as prescribed by the medical director during a student's Evaluation program. He can often supply valuable information regarding the student's motivation for and behavior in the physical restoration program.

Occupational Therapist

The occupational therapist often carries out a program of ADL or upper extremity coordination and/or dexterity on prescription of the medical director while a student is in Evaluation. She is often able to furnish valuable information regarding motivation and behavior traits observed during her work with him. On occasion, the occupational therapist will be requested by a member of the Unit staff to express an opinion as to whether or not an adaptive device would be beneficial to a student, and, if so, undertake provision of the recommended device.

Speech Therapist

The speech therapist carries out a speech and hearing evaluation on students having speech or hearing problems. Referral to speech therapist may be made by Admissions Committee at the time of scheduling and admission date for the student or by the Evaluation Unit staff. Occasionally, an active therapy program will be carried out concurrently with the Evaluation program, but is usually delayed until the conclusion of Evaluation. The speech therapist administers special tests to aphasic persons and on the basis of the results may recommend whether or not a remedial program might be effective.

Counselors

The Center counseling staff members may or may not take an active part in a student's evaluation program. They do, however, retain responsibility for "case management" of the Evaluation student in all matters - discipline, room assignment, admission orientation, authorizing purchases, etc. - other than the coordination and direct management of Evaluation procedures.

The Evaluation student's assigned Center Counselor is responsible for: (1) Arrange for "outside" specialist's examinations which may be requested by the coordinator of Evaluation or other professional staff members participating in a particular student's evaluation. The respective Center Counselor is also responsible for (2) Effect a student's "transfer" from Evaluation to training or for arranging for his or her return home. (3) Screen all medical and specialist's reports concerning students in Evaluation and are responsible for the proper routing of such reports, i.e., to the Evaluation Unit, to the referring field counselor, sponsoring agency, etc. (4) Inform coordinator of Evaluation of necessary changes. Report all interruptions or changes of schedule which may arise as a result of illness, etc. (5) Serve as a member of the Evaluation Committee. (6) Review all Evaluation reports prior to their transmittal to the referring counselor or sponsoring agency.

Recreation Personnel

The recreation director or a designated member of his staff attends the Summary Evaluation Conference and reports verbally on observations and appraisals of the student's participation or conduct in recreational activities. The recreation staff has the opportunity to observe the student in his leisure time activities, and, thus, can often supply valuable information concerning the student's ability to get along with other persons, and his social adjustment in general.

Housemothers

The housemother does not routinely attend Evaluation Conferences; however, information regarding the student's behavior on the dormitory floor is reported by her to the Coordinator of Evaluation or to appropriate Center counselor for incorporation into verbal reports at Conference. Since she observes the student in "off duty" hours, she may add substantially to the information regarding the student's social and personal adjustment to Center life.

Evaluation Report

A formal report is made to referring field counselor after a studen's evaluation is complete. Usual form:

(1) Evaluation Conference Summary by Coordinator attempts to highlight reports from various specialists and point out recommendations made by the Evaluation Committee at Evaluation Conference.

(2) Medical Reports
  (a) Medical evaluation
  (b) Progress reports
  (c) Specialist or consultative reports such as ophthalmological, orthopedic, urological, etc.
  (d) Occupational Therapy
  (e) Physical Therapy
  (f) Speech Therapy

(3) Psychological
  (a) Psychometric data sheet
  (b) Narrative report including clinical impression

(4) Job-Sample
Vocational evaluator's rating form plus narrative summary

APPENDIX XII

CHARACTERISTICS OF CLIENTS EVALUATED AT HOT SPRINGS REHABILITATION CENTER - 1964

I. DISABILITIES REPRESENTED	MAJOR	SECONDARY
a. Multiple Sclerosis	0	0
b. Anterior Poliomyelitis	21-7.6%	0
c. Arthritis	4-1.4%	1-.36%
d. Cardio-vascular Condition	5-1.8%	3-1.1%
e. Cerebral Palsy	14-5.1%	2-.72%
f. Endocrine Disorders	1-.36%	4-1.4%
g. Epilepsy	6-2.2%	12-4.3%
h. Hemiplegia	12-4.3%	5-1.8%
i. Mental Retardation	40-14.0%	19-6.9%
j. Neurological Conditions (other)	29-10.5%	4-1.4%
k. Neuropsychiatric Conditions (organic)	2-.72%	0
l. Orthopedic Conditions (other)	10-3.6%	2-.72%
m. Personality-Behavioral-Emotional	40-14.0%	11-4.0%
n. Speech and Hearing Conditions	23-8.3%	22-8.0%
o. Spinal Cord Injury	17-6.1%	0
p. Tuberculosis	3-1.1%	0
q. Visual Defect	9-3.3%	19-6.9%
r. Other	9-3.3%	4-1.4%
s. Orthopedic (Congenital)	9-3.3%	0
t. Orthopedic (Post-fracture)	9-3.3%	1-.36%
u. Orthopedic (inter-disk syndrome)	5-1.8%	0
v. Muscular Dystrophy	0	0
w. Amputee - Single	5-1.8%	2-.72%
x. Amputee - Multiple	3-1.1%	2-.72%

II. REPRESENTATIVE DATA

a. Sex

Number of male students	214-77.5%
Number of female students	62-22.4%

b. Age

Age range	15-61
Modal age	18
Median age	20

c. Marital status

Single	222-80.5%
Married	37-13.4%
Other	17- 6.2%

d. Education level

Education range	0 Grade - College Graduate
Median education level	9
Number having no formal education	5-1.8%
Number having 1 through 8 grad education *(This includes Special Education)	108-39.0%
Number having 9 through 11 grade education	78-28.2%

9th grade - 35
10th grade - 20
11th grade - 23

Number having completed high school *(This number includes Special Education and Certificate of Attendance)	79-28.6%

e. Measured Academic Achievement Level

Reading Achievement Range	0-15
Median reading level	7.3

Number measuring from 0- 2--------------------24-11.9%
Number measuring from 3- 4--------------------34-16.8%
Number measuring from 5- 6--------------------35-17.4%
Number measuring from 7- 8--------------------51-25.2%
Number measuring from 9-10--------------------29-14.3%
Number measuring from 11-12--------------------16- 7.9%
Number measuring from 13-14--------------------11- 5.5%
Number measuring from 15-16-------------------- 2- .9%

Arithmetic Achievement Range 0-14

Median Arithmetic Level 6.4

Number measuring from 0- 2--------------------17- 7.4%
Number measuring from 3- 4--------------------42-18.2%
Number measuring from 5- 6--------------------77-33.3%
Number measuring from 7- 8--------------------46-20.0%
Number measuring from 9-10--------------------26-11.2%
Number measuring from 11-12--------------------13- 5.6%
Number measuring from 13-14--------------------10- 4.3%

f. Level of Intelligence

I. Q. Range 48-121

Median I. A. 79

Number measuring I. Q. from 46- 50-------------- 1- .39%
Number measuring I. Q. from 51- 55-------------- 2- .79%
Number measuring I. Q. from 56- 60-------------- 2- .79%
Number measuring I. Q. from 61- 65--------------12- 4.8 %
Number measuring I. Q. from 66- 70--------------22- 8.7 %
Number measuring I. Q. from 71- 75--------------24- 9.5 %
Number measuring I. Q. from 76- 80--------------35-13.9 %
Number measuring I. Q. from 81- 85--------------34-13.5 %
Number measuring I. Q. from 86- 90--------------26-10.3 %
Number measuring I. Q. from 91- 95--------------31-12.3 %
Number measuring I. Q. from 96-100--------------24- 9.5 %
Number measuring I. Q. from 101-105--------------19- 7.5 %
Number measuring I. Q. from 106-110--------------12- 4.8 %
Number measuring I. Q. from 111-115-------------- 6- 2.4 %
Number measuring I. Q. from 116-120-------------- 1- .39%
Number measuring I. Q. from 121-126-------------- 1- .39%
(There are no valid I. Q. scores on some students.)

g. Work Experience

Number having had no work experience 138-50.0%

Number having worked either in competitive employment or temporary, transient short term jobs 138-50.0%

APPENDIX XIII

DESCRIPTION OF ORGANIZATION AND OPERATION OF OKLAHOMA VOCATIONAL REHABILITATION PRE-VOCATIONAL EVALUATION UNIT

Vocational Evaluation is designed to determine the assets and liabilities of the individual client as these are related to vocational goals.

For the past 25 years the Institute for the Crippled and Disabled, a comprehensive rehabilitation center in New York City, has recognized the need to provide reality vocational testing as a part of the vocational evaluation of the severely handcapped in a work setting. After considerable extension and improvement of the initial job tasks or work samples, the vocational evaluation techniques resulted in the TOWER system, published by the institute in 1957.

The development of the Oklahoma Vocational Rehabilitation Pre-Vocational evaluation Unit was based on the Utilization of this TOWER system. The program is the result of coordinated services of University Hospital and the Vocational Rehabilitation Division, thus providing more comprehensive evaluation of medical, psychological, and social functioning and appraisal of vocational abilities.

The word TOWER stands for Testing, Orientation, and Work Evaluation in Rehabilitation. The TOWER system contains a complete assembly of tests in 13 occupational areas, scoring aids, response sheets, criteria textbook, evaluation's operation manual and other materials covering a wide range of job families. In the situational setting in which the job task approach is utilized, the client is exposed to work which simulates an important sampling of the actual operations that the job itself requires in industry or business. Of these 13 TOWER standardized test areas our unit uses the following: Clerical, Drawing, Lettering, Mail Clerk, Electronics Assembly, Jewelry and Watch Repair, Welding, Power Sewing Machine Operation and General Workshops (package wrappings, sorting packaging, etc.). In addition to these areas a Drafting Test and a Stock Clerk Test was developed by the Evaluator using the TOWER system principles. The TOWER tests for leatherwork and for optical mechanics were not used due to the lack of employment opportunity in these areas and due to the great expense of materials and equipment needed for testing in these areas.

REFERRALS

Source

Referrals are received primarily from the Vocational Rehabilitation counselors. Some clients are referred to the Evaluation Unit from the Rehabilitation Medicine Clinic of University Hospital, but referrals from this source are not accepted without consent of the client's Vocational Rehabilitation Counselor. Previously a few referrals were received from the V. A. Hospital and from the Oklahoma State Employment Service, but as of January 1, 1965, such referrals are not accepted unless first processed by a Vocational Rehabilitation Counselor.

Referring Procedure

In referring clients for vocational evaluation the referral source is required to send a summary of the client's disabilities, problems presented by these, and reason for referral of the client, accompanied by copies of all obtained diagnostic evaluations (medical, psychological, social, and vocational testing previously done).

Acceptance

Upon receipt of the referral information, the evaluator, after careful review, determines whether the client might benefit from Vocational evaluation in the TOWER system and makes note of client's need for room and board during the testing period. The client and his counselor are then notified by letter regarding the scheduled testing period and room and board arrangements.

Type of referral accepted:

Any client with a physical and/or mental disability may be accepted for evaluation following review of the referral information.

Referrals received and tested since January 1, 1965

January 4	Tested	5 mentally retarded
		1 emotionally disturbed
		1 severe cardiac
February 8		15 referrals received
		11 reported and started testing February 8th
		1 of 11 who reported left after first day
		3 were rescheduled
		1 failed to report
March 8		16 referrals received
		2 were cancelled
		11 reported and started testing March 8th
		1 was rescheduled
		2 failed to report
March 29		12 referrals received to start testing March 29th

Vocational Testing

The first ½ day of the testing is devoted to orientation of the program, and to individual interviews with each client to gain some insight into their interests and attitudes. Then prior to exploration in the TOWER test areas, a battery of test is administered to each client, depending on previous testing done prior to referral for TOWER testing. These tests have been selected to obtain information regarding intelligence (revised Beta or Otis I. Q. tests), interest pattern (Kuder Preference Record), Mechanical Comprehension (Bennett Mechanical Comprehension Test or SRA Mechanical Aptitude Test), fine finger dexterity (Purdue Pegboard Test), eye-hand coordination test (THOMASAT Test), and vocational aptitude (GATB Test given at O.S.E.S.). The individual then spends the remainder of approximately a two-week testing period in exploring abilities in the TOWER test areas where he is exposed to those job activities felt to be within his physical and intellectual capacities. Each client is encouraged to attempt as many of these activities as he can, so that as broad a picture as possible of his abilities and limitations may be obtained.

An effort is made to approximate a normal working situation as closely as possible. The client reports for work from 8:30 a.m. to 3:30 p.m. five days a week during the two week evaluation period. At a given time there may be as many as 12 clients in various stages of evaluation. This two weeks association with the evaluator, the other clients, and the work environment, provides an excellent opportunity for making detailed and extensive observations of the client's overall performance and adjustments. Such factors as interests, motivation, work tolerance, work habits, and interpersonal relationships are noted.

Ratings

Performance on each work sample is evaluated in terms of industrial standard of quality and quantity. Each trade area of the TOWER system is broken down into a number of components based on a job analysis survey of competitive work standards, and encompasses the factors of speed, skill and physical requirements of the job. With these qualitative and quantitative data, performance ratings were established in five classifications:

Rating	Indication of Potential to Succeed in Training Program of Similar Nature
Superior	85% to 100%
Above Average	65% to 85%
Average	45% to 65%
Below Average	30% to 45%
Inferior	Less than 30%

A rating of average suggests that the client should be able to achieve average grades in training program of a similar nature.

On clients referred from Rehabilitation Medicine Clinic, a staffing is held following completion of the two-week evaluation period at which time members of respective disciplines (medical, psychological, social worker, evaluator and occasionally the Vocational Rehabilitation counselor) present their findings. Their findings are discussed in some detail, including their implications for probably success or failure in particular job areas. On the basis of this discussion, the evaluation report is completed by the Vocational Evaluator and submitted to the Vocational Rehabilitation counselor and to the Rehabilitation Medicine Clinic. Occasionally clients referred to the Vocational Evaluation Unit for Testing present multiple disabilities and are referred to Rehabilitation Medicine Clinic by the evaluator to obtain more detailed information about medical, social, and psychological functioning, in which case staffings follow the same procedure, as above.

Program's Value

The Evaluation Unit serves as a vocationally therapeutic laboratory, providing other professional staff members an opportunity to observe: (a) the client's adjustment to his disability among others as severely disabled as himself, (b) his potential for independent living in either outside competitive employment or a workshop setting, and (c) his interests and aptitudes with regard to future training through schooling, on the job training, or possibly self-employment.

Program's Weaknesses

1. At beginning of the testing program development, it was necessary to utilize the time and quality ratings developed by I.C.D. in New York, City. Since then the responsibility of performing the duties of a vocational evaluator as well as assuming all administrative operations of the evaluations program have totally consumed evaluators time. Thus, since beginning testing July 1, 1963, and testing 165 clients since then, there has been no opportunity to evaluate the rating system used as it relates to local employment trends, no opportunity to study current employment and training situations to determine the obsolescense of some of the tests being used, or the addition of new tests to broaden the scope of the testing program, and limited time to discuss with counselors their attitudes regarding the testing program.

2. The current program developed does not give adequate opportunity to clients with mental retardation and cerebral palsy. In January, 1965, we tested a group of five mentally retarded clients. No other clients were tested during this time. The need for improvement was observed in the current program but little time was available to initiate such improvements.

3. The purpose of Vocational Evaluation of the severely disabled is to provide as comprehensive evaluation as possible of total functioning of the individual as related to the selection of his suitable vocational goals. This includes evaluation of physical, psychological and social functioning and evaluation of vocational skills and capacities. Approximately 60 per cent of the clients seen in the Evaluation Unit are not referred to the Rehabilitation Medicine Clinic because the problems they present are not that complex. If such clients are referred to the Rehabilitation Medicine Clinic, frequently the comment received is "Why was this client referred here, we don't see that we can offer the client any particular service." Thus, in writing a report of these clients, the information contained in them is the evaluator's interpretation of medical, social, and psychological evaluation of the client, based on observation of the client and the referral information received, and definitely lack the value of the team work approach in Vocational Evaluation.

APPENDIX XIV

GUIDELINES FOR ASSESSING POTENTIALS FOR REHABILITATION

REHABILITATION MEDICINE CLINIC

UNIVERSITY OF OKLAHOMA SCHOOL OF MEDICINE
UNIVERSITY MEDICAL CENTER

Realizing that many applicants for Vocational Rehabilitation services have a variety of disabilities, some of which may be physical or psychological, or social, or vocational, (any or all of them), a Rehabilitation Medicine Clinic was organized at the University Medical Center to fully evaluate each individual patient's assets and deficits. Clients (or applicants) are referred to the clinic by the Vocational Rehabilitation Counselors and by the medical students who see patients in other clinics and send them to the Rehabilitation Medicine Clinic if they feel that they have a work potential.

The clinic is staffed by fourth-year medical students, an internal medicine specialist, who is the clinic chief, and by a psychologist, a social worker and a coordinator of rehabilitation services. Six medical students attend each clinic each day, returning the same day in the week for a period of 15 weeks. During this time they are learning about Rehabilitation Services - the types of services that are given, the policy regarding eligibility and the ways in which social agencies cooperate for the benefit of those who need them.

It is believed that when these young men start practicing medicine they will have a better idea of the needs of people and the ways in which these needs can be met than did their predecessors. Incidentally, it is felt that at the close of the 15-week period most of the medical students have a more understanding approach to people who need their help but who are handicapped by lack of finances and education, as well as by physical and/or emotional problems. They have accepted the medical concept of the whole person and the fact that during an acute illness is only a part of medical treatment today.

In general, we believe that we are getting better service for our clients by sending them to this clinic and we are also acquainting the men who will soon be in private practice with the broad concept of rehabilitation. The paramedical services are brought out in the conference which is held each morning and which is attended by the entire group. Each student presents the facts about the patient he has seen and contributing ideas are offered by the psychologist, the social worker, and the Vocational Rehabilitation representative.

At the conclusion of the work-up, which may include visits to the other clinics, special laboratory work, X-rays, social service interviews and psychological testing, a final summary is made by the student in the form of a letter sent to Vocational Rehabilitation. Incidentally, each patient is given the M.M.P.I.

test and the results are included in the final letter. Other psychological tests are given when appropriate.

Patients in this clinic are also frequently referred to the Pre-Vocational Evaluation Unit which is located nearby and which enables both the client and the clinic team members to see where his efforts should be directed.

The Vocational Rehabilitation Agency does not pay the Medical Center for the services of the doctors but it does pay a minimum fee for laboratory work, X-rays, etc. An average of ten patients are seen in the clinic each day. Two are new clients of the agency and eight are returning to see the doctor following other tests and appointments.

APPENDIX XV

Suggested Questions for Further Study

The Editorial Committee, after reviewing the material which was developed by the members of the whole committee is of the opinion that further study of the following questions at future sessions might prove to be fruitful.

1. What kinds of psychological services should the regular caseload counselor be expected to provide?

2. What types of cases should be referred for an evaluation by a clinical psychologist? A psychiatric evaluation?

3. Should eligibility and feasibility of mentally retarded and emotionally disturbed cases be determined on the basis of an evaluation by a clinical psychologist without being seen by a psychiatrist?

4. What are some of the problems involved when a field counselor:

    (a) Recommends a specialist examination when the physician who does the general medical does not feel that one is needed.

    (b) Secures a specialist examination on a case where restorative surgery has been done by the client's family doctor.

    (c) The counselor declares a client eligible when doctors who have been involved in the case do not agree.

5. What are some of the "ground rules" which should be clearly understood by the counselor and the medical consultant?

6. When a field counselor refers a client to a center for a total evaluation who should make the final determination of eligibility and feasibility? Who should decide whether center recommendations are carried out?

7. Since one of the requirements for eligibility for V. R. services is reasonable assurance that the planned services will result in remunerative employment, what is the group's reaction to accepting boarderline cases where the prognosis according to accepted rehabilitation principles is poor (Severely mentally retarded, sociopaths, public offenders, alcoholics, dope addicts, etc.)

8. What would be a workable definition of reasonable assurance?

9. Should V.R. attempt to more clearly define remunerative employment?

10. What are some effective techniques for interpreting diagnostic information in the following situations:

(a) To clients, parents and other interested individuals when a decision has been made not to accept the client.

(b) To doctors where a decision has been made not to provide recommended physical restoration services.

(c) Where the client or parents insist on a specific vocational objective which, according to accepted rehabilitation principles, is above the client's capabilities.

(d) Where recommended services, such as surgery, treatment, etc., have a reasonable chance of restoring client to the point where he will not be eligible to disability benefits? (Welfare, BOASI, VA BEC, etc.)

(e) Any type of case where surgery is involved and the client is undecided or uninformed regarding surgery which has been recommended.

11. How should the client be prepared for:

(a) Referral for medical examinations (general medical, specialist, special diagnostic procedures, etc.)

(b) Referral for a psychological evaluation.

(c) Referral for a psychiatric evaluation.

12. What are the counselor's responsibilities for supplying information to individuals, facilities or centers who are requested to provide diagnostic services? (Doctors, social agencies, psychologists, psychiatrists, testing agencies, etc.)

13. How do current methods of reporting production affect the quality of diagnostic evaluations made by the individual counselor? (Quota requirements, emphasis on 12 closures to the exclusion of all other types.) What alternate methods might be used?

14. What are some of the implications regarding pending legislation designed to extend the period of diagnosis?

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